19 February 2024

Te Whatu Ora
Health New Zealand

T Barnett
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Tēnā koe T Barnett

Your information request Reference: HNZ00035559

Thank you for your email on 8 January 2024, asking for the following which has been considered under the Official Information Act 1982 (the Act).

Te Whatu Ora Waikato Mental Health and Addictions service Policies/procedures/protocols

Please find attached as Appendix 1.

A list *of* Health NZ / Te Whatu Ora Waikato Mental Health Addiction Services (MHAS) procedures and guidelines being provided can be found overleaf.

How to get in touch

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Te Whatu Ora may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Michelle Sutherland
Group Director Operations
Waikato

Name
Access and Management of Crisis Respite
Advance Directives
After hours admissions of children and youth to HRBC and Starship
Alcohol and Drug Assessment and Stabilisation beds at Waikato and Thames Hospitals
Appointment Planning and Management of DNAs
Assaults or Threats Towards Mental Health and Addictions Service Staff
AWOL (Absent Without Official Leave)
BAO Be aware of - Crisis assessment and treatment service
Bedroom Access for Service Users - Puna Awhi-rua and Puna Maatai
Clinical Psychology Referrals and Waiting List Procedure
Clozapine - Prescribing and Monitoring
Communication Strategies to support Safe and Effective Clinical Handover and Risk Communication
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Courtyards in OPR1
Disclosure of Confidential Information Prior to Vocational Placements for Forensic Service Users
DUNDRUM Toolkit Use on the Recovery Pathway in Puawai
Duress Alarm Use and Management - Inpatient Mental Health and Addictions
Electroconvulsive Therapy (ECT)
Emergency Response in Mental Health and Addictions Community Bases
Food Safety in Puna Whiti, Puna Taunaki and Ward 41
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Integrated Care Pathway - Mental Health and Addictions
Keyworker
Leave - Mental Health Inpatient Wards and OPR1
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Levels of Observation Across All Mental Health and Addictions Inpatient Services
Opioid Substitution Treatment (OST)
Pharmacological Management of Behavioural Disturbance in the Acute Psychiatric Setting
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Recovery Planning
Requests for weekend physical monitoring of service users commencing Clozapine treatment
Safeguarding Assets (Property, Cash and Cash Assets) in Mental Health and Addictions Services Community Sites
Searching of Mental Health Service Users in Relation to Illicit Substances and Dangerous Articles
Seeking Advice and or Assessment from SMOs and RMOs at the Time of Initial Mental Health Crisis Assessment
Sensory Modulation
Service User - Tangata Whaiora Participation
Sexual Safety in Mental Health and Addictions Inpatient Units

Transport and Escort of Service User - Tangata Whaiora
Use of Personal Restraint in Mental Health and Addictions Inpatient Setting
Use of Purchasing Cards (P Cards)
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Visiting Adult Inpatient Mental Health Wards and OPR1
Whanau Inclusive Practice
Whanau Participation
Working with Risk

Te Whatu Ora
Health New Zealand
Waikato

Procedure

Access and Management of Crisis Respite

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Ellyn Gooding
Document Facilitator Title	Charge Nurse Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions clinical staff accessing respite
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Te Whatu Ora Health New Zealand assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
		Feb 2018	Full review of procedure done by CAHT charge nurse manager, associate charge nurse manager, clinical nurse specialist and operations manager. Further details added to point 2.4 and point 3 regarding respite medication.
04		June 2017	Changed into up to date procedure format Inclusion of patient information and audit indicators
05		April 2021	Updated into current DHB procedure template
06	Ellyn Gooding	July 2023	Updated into Te Whatu Ora Waikato template Changes to Crisis Respite providers

Access and Management of Crisis Respite

Contents

Access and Management of Crisis Respite

1 Overview

1.1 Purpose

This procedure describes the entry criteria and processes to be used by all Mental Health and Addictions service staff when requesting and managing crisis respite for tāngata whaiora within the Waikato District. This procedure applies to the application of crisis respite across the Mental Health ad Addictions service.

This procedure relates only to Ngā Kapua, the crisis respite service provided through the Crisis Assessment Home Treatment (CAHT) Team. This procedure doesn't cover planned respite, package of care arrangements or other respite services.

1.2 Staff group

Mental Health and Addictions staff accessing crisis respite.

1.3 Patient / client group

Mental Health tāngata whaiora experiencing an acute episode of mental illness or distress where crisis respite is considered an option.

1.4 Exceptions / contraindications

Tāngata whaiora not considered as having an acute episode of mental illness or distress requiring respite come under other package of care options or through Healthcare New Zealand planned respite processes.

Tāngata whaiora experiencing an acute episode of mental illness or distress who require a more intensive level of care.

Crisis respite is not to be utilised as a monitoring mechanism for individuals who are actively self-harming and / or are actively suicidal.

Crisis respite is not to be utilised for actual or possible substance withdrawal.

1.5 Definitions and acronyms

Crisis Respite	Crisis respite is a therapeutic intervention and supports treatment in the least restrictive and safest environment possible. Crisis respite can be used as part of a treatment plan to prevent further deterioration in mental state or as part of the discharge process from the acute inpatient unit. **Clinical responsibility remains with the referring team unless otherwise negotiated with the Crisis Assessment and Home Treatment (CAHT) Service.**
Crisis Respite Coordinator	Role that coordinates the crisis respite process. Hamilton crisis respite are overseen by the crisis respite nurse or delegate with CAHT.

	Please note – crisis respite in rural areas in managed by the local mental health service.
Crisis Respite Providers	**Ngā Kapua** Is an NGO kaupapa Māori provider who offers this respite house. Ngā Kapua is a homely environment in a residential neighbourhood. Two support workers are rostered across three shifts (am, pm, and night shift) No registered health professional are on site but staff are able to access a registered nurse for medication signing. Ngā Kapua is most suitable for clients who experience complex and challenging mental health disorders, behaviour and social / situational crisis. Ngā Kapua is more suitable for males, but also females who are familiar with mental health services.

2 Clinical management

2.1 Roles and responsibilities

Clinicians

- Clinical staff are responsible for undertaking assessments, making referrals and / or authorising crisis respite.

Managers

- Managing and monitoring the quality of crisis respite provision.

2.2 Competency required

Those making assessments / referrals or authorising crisis respite must be employed by Te Whatu Ora Waikato as a Mental Health Professional / Health Practitioner (Registered Nurse, Occupational Therapist, Social Worker, Medical Practitioner or Clinical Psychologist).

2.3 Equipment

- Referral for Case Support, Crisis Respite and Crisis Assessment and Home Based Treatment (CAHT) Service Management Form (T1298MHF)
- Consent for Respite Accommodation Form (T1026MHF)
- Mental Health progress notes (CWS electronic form)
- Risk assessment and formulation – Mental Health (CWS electronic form)

2.4 Procedure

Prior to Entry

- The mental health clinician notes a deterioration in the tāngata whaiora mental state
- The mental health clinician examines the Recovery Plan / Treatment Plan and the Advance Directive (if there is one) to examine the range of possible interventions.
- Discuss with the CAHT respite nurse to ensure a bed is available. Out of hours discussion is with CAHT through until 2330 hours. Between 2330 hours to 0800 hours consult with the HRBC coordinator.
- Complete the Crisis Respite Referral Form and tāngata whaiora consent form and then fax the completed forms to the respite provider. *Respite staff make the final determination of entry to respite.*
- Ensure the tāngata whaiora care plan is thoroughly completed with detail: including notations for every question. Not applicable (N/A) is not acceptable. E.g. *Sleeping = Client will manage own sleeping routines or; Staff to encourage awake time 9am and bedtime 10pm.*
- Explanation given to respite staff on whether tāngata whaiora is 'Formal' or 'Informal' and what that means specifically for their care plan
- Phone the respite facility and advise of the admission, also arrange a time to accompany the tāngata whaiora to the respite facility
- A contact person or a Keyworker must identify themselves or a delegate by name and provide phone numbers on the referral form
- Ensure a copy of the respite documents are uploaded to 'Documents' in clinical workstation.

One Entry

- The tāngata whaiora is to be accompanied to respite by a mental health staff member. No unaccompanied tāngata whaiora will be accepted.
- Meet with staff to discuss and explain the referral form and recovery plan
- The Mental Health clinician to ensure a progress note is completed via clinical workstation documenting the respite entry date and recovery planning information
- The Mental Health clinician to ensure the client is entered and exited from the crisis respite log book and crisis respite board
- *For medication see section 2.5 Respite Medication*
- Monitoring of tāngata whaiora: Respite staff can be asked to sight a tāngata whaiora at particular time intervals. Please talk to respite staff about the frequency of sighting the tāngata whaiora requires.
- Document and discuss the frequency of monitoring, for example, will verbal engagement be required, sight only, or will questions need to be asked of tāngata whaiora.

During Respite

- Tāngata whaiora in respite require a daily face to face review by a mental health clinician (excluding weekends and public holidays by Community Mental Health teams).
- The clinician needs to phone respite and arrange a suitable time to visit
- When visiting, the clinician must inform respite staff when they arrive and when they depart from the visit
- Use a private space for private conversations
- During the review with tāngata whaiora, continue to discuss and update the recovery goals and plan. Include discharge planning.
- Whilst still in respite, tāngata whaiora can begin transition back home, for example, leaving respite to return home for a few hours, and then return to respite, increasing timeframes away from respite to eventually leave respite entirely.
- Following the daily review with the tāngata whaiora, the clinician must verbally provide an update to respite staff and ensure the information is also documented in the tāngata whaiora respite file.
- Ensure a Te Whatu Ora Waikato Progress Note is completed via clinical workstation at each review. Include the recovery plan.
- Ensure the CAHT Respite Nurse is regularly updated on the tāngata whaiora length of stay
- If crisis respite staff contact the mental health service with concerns regarding a tāngata whaiora, the mental health service must respond as soon as possible. Response may initially be via phone call to triage the concern and plan further. During working hours the tāngata whaiora treating team will respond. Out of hours, CAHT will respond. CAHT will respond at all times to tāngata whaiora under their care.
- Where crisis respite staff have concerns requiring an emergency response, they will phone 111, for example, medical emergency or imminent threat to personal safety of the tāngata whaiora or staff.

Exiting Respite

- Ensure the tāngata whaiora and respite staff are included in the discharge plan
- Ensure all belongings are with the tāngata whaiora when they leave respite
- Liaise with the respite nurse or community mental health team regarding tangata whaiora being given their medication (safety and risk management)
- Ensure a Te Whatu Ora Waikato Progress Note is completed via clinical workstation, including the respite exit date
- Ensure the CAHT Respite Nurse is informed of the tāngata whaiora departure
- If an extension to the length of stay is required, the Keyworker / Mental Health Professional will discuss this with the Respite Coordinator / CAHT service

- If the extension is agreed , the Respite Coordinator / CAHT service will confirm the extension with the respite provider and ensure the exit date is amended on the respite record
- The Keyworker / Mental Health Professional documents their assessment and process of decision making within the Mental Health progress notes and update the 'Referral for Case Support, Crisis Respite, and CAHT service management form' (T1298MHF), ensuring the respite provider receives a copy of all relevant information.

2.5 Respite Medication

Respite providers are required to adhere to specific guidelines regarding medication packaging, storage and administration.

It is vital that Te Whatu Ora Waikato staff support the guidelines to ensure tāngata whaiora have access to prescribed medication.

ALL medication going to respite must be blister packed. No exceptions.

Physical medication and mental health medication MUST be blister packed separately from each other, i.e., one blister pack for physical medications and one blister pack for mental health medication.

A signing sheet must accompany the blister pack/s, otherwise respite staff will be unable to sign against the medication.

Include a current copy of the tāngata whaiora prescriptions for both the physical and mental health medication on admission.

No Controlled Drugs are to be sent to respite, for example morphine tablets for pain relief. There are no exceptions. Controlled Drugs are to remain at the Pharmacy or at an inpatient Henry Rongomau Bennett Centre (HRBC) ward. The mental health clinician will need to make daily arrangements for the tāngata whaiora to receive the medication, such as, collecting the medication from the ward and delivering the dose.

The clinician must ensure the tāngata whaiora has adequate medication so as not to run out afterhours or over weekends.

2.6 Rural Respite Services

Rural services are encouraged to utilise local respite services in the first instance, however, crisis respite in Hamilton is available if local services are not.

Expectations on entry, during and exiting of respite remains as previously outlined.

Given geographical factors, it may not be possible for the rural clinician to visit and review the client daily. In these cases rural clinicians are to contact CAHT and make other arrangements. Contact can be made with the respite nurse or CAHT CNM / ACNM. It may be appropriate that the tāngata whaiora care is temporarily transferred to CAHT whilst they are in respite and returned to the rural clinician upon exit and return home. This is to be negotiated and documented.

There will also need to be a discussion as to which Doctor will provide oversight – Rural or CAHT.

3 Patient information

- Tāngata whaiora must be provided the pamphlet explaining what crisis respite is.
- Conditions of respite are included in the contract signed by tāngata whaiora.

4 Audit

4.1 Indicators

- Tāngata whaiora feedback on crisis respite.

4.2 Tools

- Exit questionnaire is completed by tāngata whaiora
- Feedback is discussed at a quarterly formal meeting between Te Whatu Ora Waikato and Providers

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Advance Directive procedure (2181)
- Mental Health and Addictions Working with Risk: Assessment and Intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others protocol (5241)
- Mental Health and Addictions Transport and Escort of Tāngata Whaiora procedure (1863)
- Clinical Records Management policy (0182)
- Medicines Management policy (0138)

5.2 External Standards

- NZS8134:2021 Ngā Paerewa Health and Disability Services Standard
- Ministry of Health (2013) Medicines Management Guide for Community Residential and Facility-based Respite Services – Disability, Mental Health and Addiction. Wellington: Ministry of Health.
- Ministry of Health (2017). Adult Mental Health Services – Adult Crisis Respite – Mental Health and Addictions Services tier three service specification April 2017. Nationwide Service Framework.

Advance Directives

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Julie Kneebone
Document Facilitator Title	Consumer Development Advisor
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
04	Julie Kneebone	May 2017	Updated with current electronic process. Inclusion of indicator. Person centred flow for advance directives development

Advance Directives

Contents

Advance Directives

1. Overview

1.1 Purpose

This procedure outlines the steps to be followed when:

- Guiding a service user / tāngata whaiora to make an advance directive
- How to proceed when a service user / tāngata whaiora presents with an advanced directive
- What to do when a service user / tāngata whaiora revokes their advance directive

1.2 Scope

This procedure is applicable across the Mental Health and Addictions service

1.3 Patient / client group

Mental Health and Addictions service users / tāngata whaiora

1.4 Exceptions / contraindications

Nil

1.5 Definitions

An "Advance Directive" is defined in the Health and Disability Service Standards (2008) as a written or oral directive:

a. By which a service user makes the choice about a possible future health procedure; and

b. That is intended to be effective only when they are not competent"

A service user may use an advance directive to give health care direction in advance.

2. Clinical Management

2.1 Competency required

A Psychiatrist / treating clinician must check the person is legally competent when deciding the validity of an advance directive

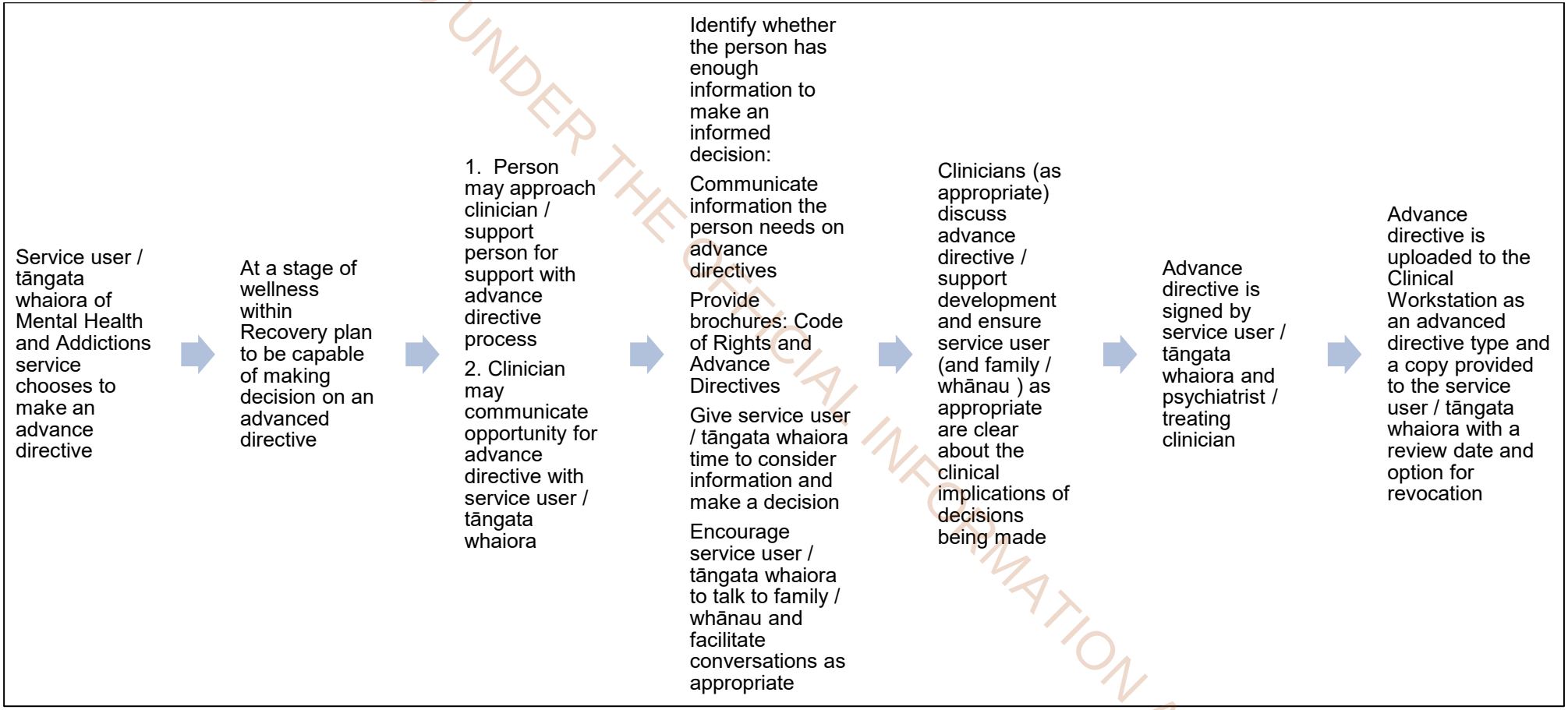
2.2 Equipment

Clinical Record
Advance Directive template - electronic

2.3 Procedure

This procedure is divided into four sections:
Section One: Person Centred Care approach to advance directives
Section Two: Procedure for Mental Health Professionals when a service user / tāngata whaiora request guidance / support to make an advanced directive
Section Three: Procedure for Mental Health Professionals when a service user / tāngata whaiora presents with an advance directive
Section Four: Procedure for Mental Health Professionals when a service user / tāngata whaiora revokes their advance directive

Section One: Person centred care approach to making an advance directive



Section Two: Procedure for Mental Health Professionals when a service user / tāngata whaiora requests guidance / support to make an advance directive

1. Action:

Ensure that the service user / tāngata whairoa has been provided with enough information to make an informed decision inclusive of the Advance directive information for service users (G1452MHF) brochure. For example does the service user / tāngata whaiora realise what the consequences or risks of their decisions are especially in relation to refusal of particular medications e.g. anti-psychotics

Rationale

A well-informed service user / tāngata whaiora is more likely to make wise decisions

2. Action:

Encourage the service user / tāngata whaiora to think about whether they would like any of their family / whānau members to have a copy of their advance directive.

Rationale

Family / whānau members having a copy of the advance directive may help when the service user / tāngata whaiora is admitted to an acute inpatient unit outside of working hours.

3. Action:

Encourage open discussion about the clinical nature and impact of the service user's / tāngata whaiora's decisions before the advance directive is made. Encourage involvement of the service user's / tāngata whaiora's keyworker

Rationale

Service user is aware of options for best treatment from a clinical perspective.

4. Action:

If the service user / tāngata whaiora is not legally competent at the time of wishing to make an advance directive, inform him / her that he / she will be unable to make an advance directive until they are well as it will be invalid due to their lack of competence.

Rationale

Service user / tāngata whaiora needs to be competent to make an advance directive that will have validity

5. Action:

If the service user / tāngata whaiora is fully informed, not unduly influenced or pressured and is capable to make an advance directive, the service user / tāngata whaiora completes the

advanced directive in their time. Staff provide the service user / tāngata whaiora with the relevant information. To be uploaded to the clinical workstation the advanced directive must be signed by the service user / tāngata whaiora and the clinician. The advanced directive must be signed and scanned into the clinical workstation to be valid for use.

Rationale

Standardised process is used

6. Action:

The psychiatrist / treating clinician signs the top section of the advance directive

Rationale

An advance directive signed by a psychiatrist / treating clinician will hold more validity.

7. Action:

Once signed by a psychiatrist / treating clinician the advanced directive is entered into the electronic system, and the hard copy is provided to the service user / tāngata whaiora within five working days, and a copy placed on the service user's / tāngata whaiora clinical record with their approval.

Rationale

To ensure consistency across the service

Section Three: Procedure for Mental Health Professionals when a service user / tāngata whaiora presents with an advance directive

1. Action:

When an advance directive is presented the psychiatrist / treating clinician must check the validity of the advance directive by:

- Checking for the statement of competence from doctor at top of page one. If this is not present it does not, on its own, mean that the advance directive is invalid
- Check that the advance directive is current and mental health specific (not revoked)
- Ask service user / tāngata whaiora / family / whānau members, as appropriate if advance directive is to be followed in presenting situation
- Consult with service user's / tāngata whaiora's keyworker

Rationale

Need to ascertain service user / tāngata whaiora was legally competent at time of making the advance directive.

Need to ensure these are the service user / tāngata whaiora's actual wishes.

Need to ascertain that the service user / tāngata whaiora was fully informed about the decisions and possible clinical consequences of wishes stated in the advance directive.

Occasionally older people from rest homes may have an advance directive (care plan) that is not mental health related.

2. Action:

After checking the validity of the advance directive the psychiatrist / treating clinician may:

- Follow the advance directive if he or she has reasonable grounds to believe it is valid and the treatment outlined is appropriate
- Decline to follow the advance directive if she or he has reasonable grounds to override on the basis of wellbeing for the service user tāngata whaiora
- If the service user / tāngata whaiora is under the Mental Health Act 1992, consideration should still be given to following the advance directive if clinically appropriate to do so.

Rationale

If you do not follow the directions of an advance directive and there is no reason to doubt the validity and 'reasonableness' of the advance directive, it could be seen as a breach of Right 7 of New Zealand's Health and Disability Service users' Rights "*Right to Make an Informed Choice and Give Informed Consent (rule 7 (5) states that Every Service User may use an Advance Directive in accordance with the common law").*

3. Action:

The psychiatrist / treating clinician must document the rationale for the above decision in the service user's / tāngata whaiora individual clinical record.

At an appropriate point in the service user / tāngata whaiora journey, information on the rationale for not following the advance directive should be offered to the service user / tāngata whaiora.

Rationale

Record of decision made

Section Four: Procedure for Mental Health Professionals when a service user / tāngata whaiora revoke their advance directive

1. Action:

When a service user informs any health professional that they wish to revoke their advance directive you need to discuss the decision with the service user / tāngata whaiora and discuss with appropriate members of the multidisciplinary team.

Rationale

The service user tāngata whaiora can choose to terminate their advanced directive at any time. The Psychiatrist / treating clinician will need to assess the choices made in line with the ability of the service user / tāngata whaiora at the time.

HDSS Right 7 (4) "*provider may provide services where it is in the best interests of the consumer and reasonable steps have been taken to ascertain the views of the consumer*"

3. Action:

If the psychiatrist or treating clinician finds the service user / tāngata whaiora is competent they need to:

- Ask the service user / tāngata whaiora if they wish to alter the advance directive or make a new one rather than just revoke the existing one
- Document in the service user's / tāngata whaiora current clinical record the revocation and document the revocation on page 3 of the advance directive
- Inform the service user's / tāngata whaiora keyworker

Rationale

The service user / tāngata whaiora is given choices to continue to use an advance directive or not.

To ensure that the service users / tāngata whaiora wishes are current.

3. Patient Information

Health and Disability Commissions information pamphlet on advance directives
Advance directive information for service users (G1452MHF)
Advanced directive template
Revocation template

4. Audit Indicators

4.1 Indicators

Number of service users / tāngata whaiora with signed advanced directives

4.2 Tools

Quarterly monitoring of signed advanced directives

5. Evidence Base

5.1 Summary of Evidence, Review and Recommendations

5.2 References

Associated documents

Advance Directive Template and Revocation template - electronic
Health and Disability Commissions information pamphlet on advance directives
Advance directive information for service users (G1452MHF)
Waikato DHB Informed Consent Policy (0182)

References

Health and Disability Services Standards NZS8134:2008

The Code of Health and Disability Services Consumers' Rights (1996)

Waikato District Health Board

Procedure

After hours assessment and Admission of Children and Youth to the Henry Rongomau Bennett Centre and Starship

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Jik Loy
Document Facilitator Title	Clinical Director ICAMHS
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	All Mental Health and Addictions staff and specifically: - Medical staff assessing the need for admission of children and youth - Health professionals facilitating the admission of children and youth
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
3	Jik Loy	21 May 2019	Updated to current procedure template Change in name of Act from Children, Young Persons, and Their Families Act 1989 to the Oranga Tamariki Act 1989, Children's and Young People's Well-being Act 1989. Updating of contact information

After hours assessment and Admission of Children and Youth to the Henry Rongomau Bennett Centre and Starship

Contents

After hours assessment and Admission of Children and Youth to the Henry Rongomau Bennett Centre and Starship

1 Overview

1.1 Purpose

For the assessment and management of young people under the age of 18 who require mental health services, to ensure the young person is assessed, and if required admitted to the Child and Family Unit, Starship Auckland as soon as practicably possible.

1.2 Scope

This procedure applies to the after-hours assessment and management of young people under the age of 18 by health professionals in the Mental Health and Addictions service.

1.3 Patient / client group

The client group is young people (under the age of 18) requiring mental health assessment and management after hours.

1.4 Definitions

Child and Family Unit Starship	A supra-regional acute psychiatric child and adolescent mental health inpatient unit hosted by the Auckland District Health Board.
Oranga Tamariki Ministry of Children	Government service who become involved in a child's life when there are concerns about the wellbeing of a child / young person.

2 Clinical Management

2.1 Roles and Responsibilities

Health professionals involved in the care of young people after hours are required to follow the processes within this procedure.

Registrar / SMO on call / Nurse Practitioner make the decision regarding the need for a young person to be admitted to an inpatient mental health unit and discuss this with the on call SMO.

On call SMO contacts the on call Starship consultant when a young person requires admission to Starship.

Duly Authorised Officers (DAO) are required to carry out the powers and functions of a DAO under the Mental Health Act.

2.2 Competency required

All health practitioners are required to meet the competency requirements of their discipline.

2.3 Equipment

- Clinical workstation
- Telephone
- Computer

2.4 Procedure

Initial triage is completed by the Crisis Assessment and Home Based Treatment Service (CAHT) or the Henry Rongomau Bennett Centre (HRBC) After Hours Coordinator.

Assessment is conducted either by the Emergency Department (ED) mental health team or CAHT Service or the Duty Psychiatric Registrar or Nurse Practitioner, depending on the presenting issues and the time of presentation.

Assessment by the Duty Psychiatric Registrar or Nurse Practitioner is required if medication prescribing or acute inpatient admission is considered.

The caregiver / guardian should be present with the young person, although the young person may be asked to speak with an assessor on their own.

- If the young person does not have a caregiver / guardian present, clinical assessment can be commenced, but the interviewer needs to consider issues of informed consent and risk management planning, in the absence of a responsible adult.
- If Oranga Tamariki (Ministry for Children) is already involved with the young person (i.e. has custody or shared custody) the expectation is that an Oranga Tamariki Social Worker / caregiver are present.
- If the caregiver / guardian cannot be present by the time that the assessment is concluded, they should be consulted by phone to be involved in the treatment and risk management planning process
- If contact cannot be made with the caregiver / guardian (for patients under 16 years of age) then Oranga Tamariki (Ministry for Children) should be notified and their attendance requested for the assessment, if possible.

Contact information for Oranga Tamariki (Ministry for Children):	
Monday to Friday 0800 – 1700hrs	Telephone 0508 FAMILY (0508 326 459)
From 1700hrs to 0800hrs Monday to Friday and weekends and public holidays	Social workers are only available to assess emergency situations. But you are encouraged to call if you are unsure. Email: contact @ot.govt.nz

If the caregiver / guardian cannot be contacted, is not willing or able to take responsibility for the young person, or the young person does not wish to be returned to their caregiver / guardian, and acute mental health intervention is not required, then it should be recommended to police to place the child or young person in the custody of the chief executive by delivering the child or young person to a social worker, under Section 48 of the Oranga Tamariki Act 1989, Children's and Young People's Well-being Act 1989.

Clinical Documentation

All relevant clinical documentation is to be forwarded by email to the relevant Child and Adolescent Mental Health cluster (as below) for children / young persons assessed after hours by the clinician(s) facilitating the assessment as well as to their family doctor.

Clinical documentation must be forwarded regardless of the outcome of the assessment to ensure the relevant cluster is aware of the outcome and can provide follow up following their acute cluster process respectively.

Cluster	Contact information
Hamilton / Central cluster – Ngā Ringa Awhina (includes Te Aroha)	0800 999 903 Email: inward.referrals.NRA@ngaaringaawhina.org.nz
Hauraki cluster – Ko Ngā Tatai Tu Kauri	0800 726 849 Email: icamsaccistriage@waikatodhb.health.nz
Southern Waikato cluster – Ko te Pataka Oranga o te Ao Wairua	0800 154 973 Email: icamhs-southcluster@waikatodhb.health.nz

Possible pathways / assessment outcomes:

If assessed as **not requiring acute mental health intervention**, the young person remains in the community with the appropriate support and follow up. It is expected that the clinician(s) who makes this recommendation after hours, follows his / her line of clinical responsibility (i.e. Duty Psychiatric Registrar has discussed with the Waikato DHB On Call Consultant).

Pathway options	Actions required
Home with family or extended support	It is expected that the young person is reviewed as per acute cluster pathway by the relevant Child and Adolescent Mental Health cluster.
Home with family or extended family with the support of agency care staff	The rationale, roles and responsibilities of agency staff is to be clearly documented in the clinical record. Family are to be given written and verbal information regarding who to call if the situation deteriorates. It is expected that the young person is reviewed as per the acute cluster pathway by the relevant Child and Adolescent Mental Health cluster.

	Invoices are forwarded to the Child and Adolescent services to be paid under the Child and Adolescent Package of Care.
Respite accessed through Emerge Aotearoa (24/7 pastoral care for youth)	Referrals are able to be accepted after hours by contacting 07 858 4206 or the Service Delivery Manager on 027 223 3256. Additional staff for 1:1 supervision in respite can be arranged with clearly documented rationale, roles and responsibilities in the clinical record. Relevant clinical documentation will be faxed to Emerge Aotearoa fax number 07 858 4205 prior to the young person's arrival. Invoices for 1:1 supervision are forwarded to the Child and Adolescent service to be paid under the Child and Adolescent Package of Care.

If assessed as **requiring acute mental health intervention;** the assessment, formulation, diagnosis / impression and recommendations need to be discussed with the Waikato DHB on call consultant.

Pathway options	**Actions required**
Admission to Child and Family Unit (CFU) Starship Hospital *The Waikato DHB funds beds in the Starship Hospital for children and youth from the Waikato area and these beds can be accessed 24/7.*	The Waikato DHB Consultant will contact the Starship on call Consultant on 09 367 0000 to request acceptance of the admission. When a young person is deemed to require admission, whenever possible this should occur without delay. The responsibility for ensuring that the young person is safe to transport to Auckland rests with the Waikato DHB on call Consultant, or the Duly Authorised Officer (DAO) (if under the Mental Health Act). Please refer to the Mental Health and Addictions transport and escort of service user procedure (1863).
Admission to the Henry Rongomau Bennett Centre (HRBC) *May be considered if the young person is unable to travel to Starship CFU due to health and safety concerns(e.g. young person's mental state / behaviour);*	Formal admission process is completed to the ward. Appropriate placement of the young person within the ward area. Youth presenting for admission awaiting transfer to specialist inpatient service at

resource constraints; weather conditions; bed unavailability.	Starship require high risk observations as per the Mental Health and Addictions levels of observation in inpatient services procedure (5238) Review of admissions must occur on a daily basis, by ICAMHS during working hours or the Duty Psychiatric Registrar / Consultant after hours. When transfer to Starship CFU is considered safe and appropriate, this is to occur without delay and be facilitated as soon as practicable.
Emergency Department Short Stay at Waikato Hospital *To be considered in situations whereby the young person requires short-term monitoring due to medical concerns requiring extended observation for clinical reasons.*	As negotiated with ED Nurse in charge of the shift.

3 Patient information

Written information is provided to families when a child is discharged home after hours as to who to call if the situation deteriorates.

Child, Adolescent & Youth Mental Health Service Pamphlet (G1005MHP)

4 Audit

4.1 Indicators

- Young people requiring an inpatient admission are admitted without delay to the most appropriate inpatient unit given the context.

4.2 Tools

- An incident form is completed when admissions to an inpatient unit are not able to be managed to support safe, efficient, and effective care delivery.

5 Evidence base

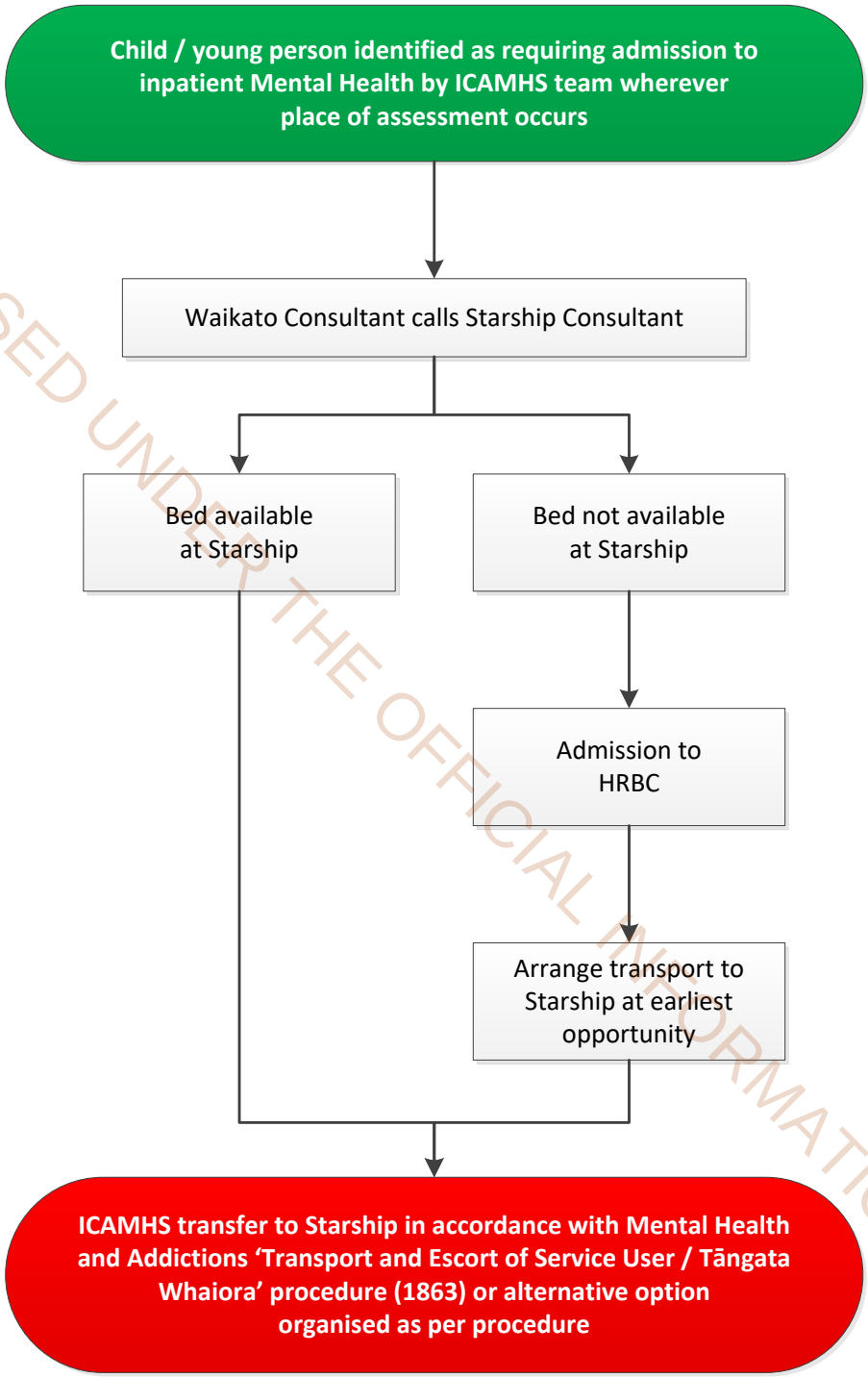
5.1 External Standards

- Health and Disability Commissioners' code of Health and Disability services Consumers' Rights 1996
- Health and Disability Services Standards NZS 8134:2008
- Health Practitioners Competence Assurance Act 2003
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Oranga Tamariki Act 1989, Children's and Young People's Well-being Act 1989
- http://www.legislation.govt.nz/act/public/1989/0024/127.0/DLM147088.html. Accessed 21 May 2019.

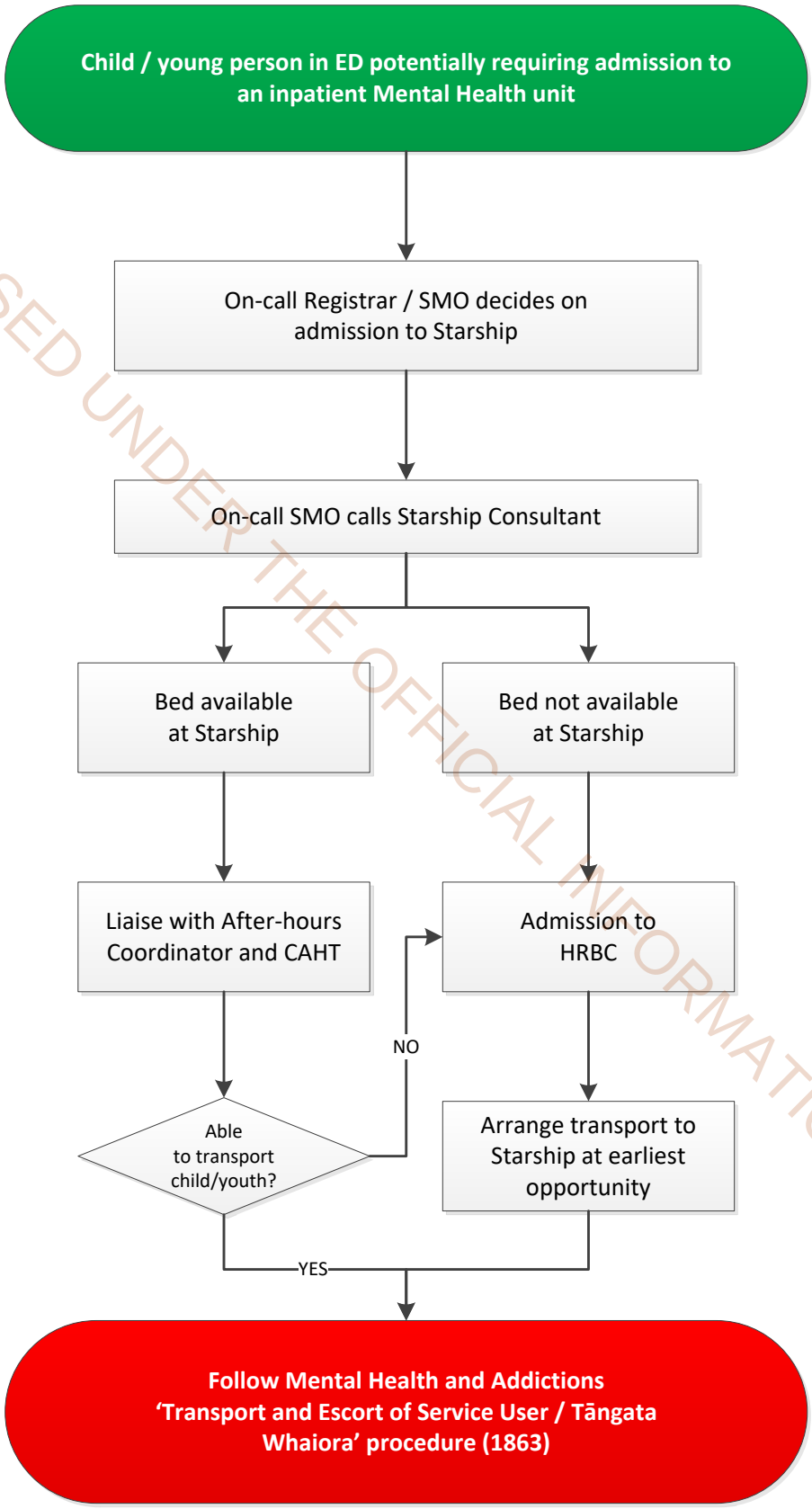
5.2 Associated Waikato DHB Documents

- Mental Health and Addictions Levels of Observation in Inpatient Services procedure (Ref. 5238)
- Mental Health and Addictions Transport and Escort of service user / tāngata whaiora procedure (Ref. 1863)
- Waikato DHB Admission, Discharge and Transfer policy (Ref. 1848)
- Waikato DHB Informed Consent policy (Ref. 1969)
- Consent to Treatment (A3114MHF)

Appendix A – Transfer Process During Working Hours



Appendix B – Transfer Process After Hours



Waikato District Health Board

Procedure

Alcohol and Drug Assessment and Stabilisation Beds at Waikato and Thames Hospitals

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Louise Leonard
Document Facilitator Title	Nurse Practitioner
Document Owner Name	Dr Andrew Darby
Document Owner Title	Clinical Director Alcohol and Drug
Target Audience	Hospital staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
4	Louise Leonard	22/06/2020	Thames hospital beds added and Waikato beds now in a medical unit
			Replaces 3321 Version 3

Alcohol and Drug Assessment and Stabilisation Beds at Waikato and Thames Hospitals

Contents

Alcohol and Drug Assessment and Stabilisation Beds at Waikato and Thames Hospitals

1 Overview

1.1 Purpose

This procedure details the processes for accessing and managing the Alcohol and Drug Assessment and Stabilisation beds. The beds are situated in ward A3 at Waikato hospital and in the Medical Inpatient Unit (IPU) at Thames hospital.

1.2 Scope

This procedure applies to the use of the Alcohol and Drug Assessment and Stabilisation beds in in ward A3 at Waikato hospital and the Medical Inpatient Unit (IPU) at Thames hospital.

1.3 Patient / client group

Alcohol and drug patients / tāngata whaiora.

1.4 Exceptions / contraindications

The Alcohol and Drug Assessment and Stabilisation beds are for short stay admissions only and cannot be used for patients with undifferentiated physical and/or mental health needs, or accommodation needs, which are yet to be determined.

The Alcohol and Drug Assessment and Stabilisation beds are not for acute psychiatric admissions.

1.5 Definitions

CIWA-AR	Clinical Institute Alcohol Withdrawal Assessment Revised scale
A&D Beds	Alcohol and Drug Assessment and Stabilisation beds
Medical IPU	Medical inpatient unit
CADS	Community Alcohol and Drug Service
NP	Nurse Practitioner
MO	Medical officer
HO	House officer
AOD NGO	Alcohol and Other Drug non-government organisations
NRT	Nicotine replacement therapy

2 Clinical Management

2.1 Roles and Responsibilities

- Patients will be admitted under the CADS consultant. Admission will be conducted by the CADS NP or MO with support from the CADS HO or Registrar or the Medical IPU HO who will do the physical exam and bloods.
- The Medical IPU SMOs will provide consultation and advice on medical issues.
- CADS SMO, NP, Registrar or HO will review the patient daily.

2.2 Competency required

A registered nurse must be the primary nurse for this patient and is responsible for monitoring the patient.

2.3 Equipment

- Quiet calm environment
- Single room with ensuite toilet facilities if possible
- High low bed
- Pen light torch
- Sphygmomanometer
- Stethoscope
- Thermometer
- Vomit container
- EWS observation chart
- Pulsometer / Oxometer
- CIWA-AR monitoring tools
- Reflex hammer
- Tuning fork
- Auroscope
- Scales
- Medications as prescribed

2.4 Procedure

The Alcohol and Drug Assessment and Stabilisation beds are for patients who:

- Are 18 years old and over
- Have a moderate to severe substance use disorder as their current primary concern
- Require a safe environment for a **short period** of time to allow for further alcohol and drug assessment and treatment to commence
- Must be under the care of the Waikato DHB CADS teams (urban and rural).
- May already occupy a bed in either the general hospital or mental health inpatient facility. However at the time of transfer to the Alcohol and Drug Assessment and Stabilisation bed the patient does not meet criteria for acute psychiatric admission or acute medical admission.

There are two points of entry for admissions to the Alcohol and Drug Assessment and Stabilisation beds. The CADS Hamilton and Thames teams will manage admissions to the beds. Mental health and addictions clinicians who consider an identified patient would benefit from admission to these beds must contact the CADS SMO, NP, MO, CNM or Detox nurse to discuss referral to CADS Hamilton who will contact the referrer to discuss admission.

Allocated CADS staff will determine admission decisions after the completion of a comprehensive alcohol and drug and risk assessment and treatment plan. Following discussion with the referrer, priority for admission will be determined and the referrer will be advised of a tentative admission date if appropriate. This date will be confirmed as soon as possible.

Planned admissions are generally admitted Mondays and Tuesdays mornings (9am) for Thames hospital and Tuesday and Wednesday mornings for Waikato hospital generally with a length of stay 5 – 7 days, occasionally up to 14 days if deemed appropriate by CADS.

CADS staff must advise the Ward A3 or Medical IPU CNM of the admission at least 24 hours prior to ensure a bed is available.

CADS keyworker will:

- Ensure contact details, NOK etc. and all documentation in the patient's clinical record is up to date.
- Maintain contact with the patient whilst they are an inpatient and liaise with whānau and AOD NGO providers and other relevant stakeholders e.g. community pharmacists (if applicable).
- Inform the patient's General Practitioner of the admission
- Organise appropriate transport for the patient to and from the A&D beds.
- Identify 'safe and supportive' visitors who will support the recovery process.

Ward A3 and Medical IPU Registered Nurse will:

- Ensure single room is available if possible;
- Clear room of alcohol based hand sanitiser;
- Remove sharps container;
- Ensure name on electronic whiteboard;
- Labels printed;
- Set up the admission documentation (sample in ward office cubby hole – contains procedure/consent form/blood form/ nursing admission assessment/ CIWA-Ar/ National medication chart).
- Assign experienced nurse for first 3 days if possible
- Read and familiarise yourself with procedure (3321)
- Greet the patient and their family/whanau and orientate them to the environment.
- Complete a full nursing admission including CIWA-Ar score and vital signs. Complete weight, height and ECG.
- Ask for patients medications.
- Perform property check of all bags and clothing. Confiscate any contraband (cigarettes, alcohol and illicit or non-prescribed drugs).
- Document all individual items on property sheet.
- Ensure patient has adequate food and fluids available to them.
- 'Identified' visitors report to reception desk.
- Inform CADS NP or MO of any concerns as they occur.
- Maintain communication with CADS staff as necessary.

- After 3rd day:
  - Patient may go out for brief unescorted leave following a review by CADS MO or NP during Monday to Friday normal work hours.
  - If the patient (who is a voluntary admission) insists on going out for a smoke break prior to Day 3, despite NRT being offered, family or trusted friend to escort if possible.
  - If patient returns to the ward intoxicated or smelling of alcohol they should be discharged.

2.5 Potential complications

There are limited resources and a lack of facilities to manage medical detoxification therefore admissions must be planned and carefully managed to ensure safety of patients and staff.

The Alcohol and Drug Assessment and Stabilisation beds are not for acute psychiatric admissions. Additionally admissions to the beds are not suitable for patients with acute, complicated medical conditions such as severe hepatic cirrhosis.

Safe transport to and from Thames and Waikato hospitals will be arranged by CADS keyworker in conjunction with family/whanau. A back up plan must be in place for early discharge against medical advice.

Patients must not drive themselves to admission to the A&D beds as they are likely to be either under the influence of alcohol and drugs or in acute withdrawal.

As there are only two beds in each location, priority must be given to those patients who are most acute in terms of their need for safe alcohol withdrawal management.

2.6 After care

At the time of admission a comprehensive discharge plan, which includes after care, will already be in place.

3 Patient information

Patients will be provided with an admission letter detailing the time, date and location of their admission.

The letter will also highlight the conditions of admission i.e. not to leave the ward for 72 hours so that alcohol withdrawal can be adequately monitored; Non- smoking policy – NRT will be utilised for the first 72 hours.

There are whānau accommodation facilities available on the Thames hospital campus.

4 Audit

4.1 Indicators

- Patients receive care in the alcohol and drug assessment and stabilisation beds as appropriate to the context of their clinical condition.

4.2 Tools

- Incident reporting system
- CIWA-AR
- EWS

5 Evidence base

5.1 Bibliography

- Matua Raki Substance Withdrawal management guidelines 2019

5.2 External Standards

- Health and Disability Services Standards NZS8134:2021
- Alcoholism and Drug Addiction Act 1966
- Human Rights Act 1993
- Code of Health and Disability Services Consumers' Rights Act 1994

5.3 Associated Waikato DHB Documents

- Alcohol, Illicit Substances and Drug Abuse – Patient and Visitors policy (1831)
- Alcohol Withdrawal, Management of patients presenting with procedure (2672)
- Medicines Management policy (0138)
- Opioid Substitution Treatment Policy (methadone and buprenorphine – naloxone) in Waikato Hospital procedure (2881)
- Smokefree / Tobacco free – Auahi Kore / Tupeka Kore policy (0121)
- Thiamine drug guideline (2190)
- Mental Health and Addictions Transport and Escort of service users / tāngata whaiora (1863)
- Alcohol and Drug Bed Agreement to Treatment Contract (A2018MHF)
- Clinical Institute Withdrawal Assessment for Alcohol Revised (A1269MHF)
- Amphetamine Withdrawal Observation Chart (A1268MHF)
- Signs and Symptoms of Benzodiazepine Intoxication Recording Chart
- Cannabis Withdrawal Observation Chart
- Opiate Withdrawal Observation Chart
- Waikato DHB Adult Vital Signs Chart (A7182HWF)

Appointment Planning and Did Not Attend Management with Tāngata Whaiora

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Nicola Livingston
Document Facilitator Title	Operations Manager, Mental Health and Addictions Service
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director, Mental Health and Addictions service
Target Audience	Mental Health and Addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
6	Gerard Pauley	12/07/2018	DNA definitional change to reflect full definition, removal of two part DNA procedure on the basis of risk, rewording of appointment reminders and persistent non-engagement sections.
7	Nicola Livingston	1/08/2022	Full review of document Transferred to Te Whatu Ora template and language changed from Waikato DHB to Te Whatu Ora throughout document. Term persistent non-engagement changed to repeated non-engagement Inclusion of a statement about appointment planning in Section 2. Clinical management Inclusion of proposed 6 monthly audit Inclusion of Appendix A: A guide to recording DNA stats

Appointment Planning and Did Not Attend Management with Tāngata Whaiora

Contents

Appointment Planning and Did Not Attend Management with Tāngata Whaiora

1 Overview

1.1 Purpose

The purpose of this procedure is to ensure that all Te Whatu Ora Health Professionals working within Mental Health and Addictions Services (MH&AS) follow a clear procedure when booking appointments, and when reminding tāngata whaiora of their appointments, in response to a DNA (Did Not Attend) and when there has been repeated non-engagement with treatment.

1.2 Scope

Applies to all health professionals working in the Mental Health and Addictions services.

1.3 Patient / client group

Tāngata whaiora of the Mental Health and Addictions service.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

Did Not Attend (DNA)	A DNA occurs when tāngata whaiora does not attend an arranged appointment and does not make contact at any point prior to the appointment to either cancel or reschedule. A DNA can occur at Te Whatu Ora facilities and other venues, for example, tāngata whaiora / whānau home, a General Practitioner surgery or a pharmacy.
Keyworker	A Keyworker is a registered health professional who coordinates care for the tāngata whaiora, including external agency input. They are responsible for coordinating the treatment care/recovery/relapse prevention planning process, including transfer of care planning, and all documentation. They are the primary point of contact within the service for the tāngata whaiora and their whānau.

2 Clinical management

Effective clinical practice involves engagement with tāngata whaiora and their whānau in a way that enables their inclusion in their recovery journey. Ongoing engagement and relationship building can be enhanced through meeting with tāngata whaiora and their whānau in person at appointments, and ensuring appointments are made in consultation with tāngata whaiora and their whānau with the aim of reducing potential barriers to attending.

2.1 Roles and responsibilities

Clinicians

- Engage with tāngata whaiora and whānau to support their attendance at planned appointments.
- Follow the appropriate procedure should tāngata whaiora not attend an appointment.

Managers

Support clinicians around the decision-making that occurs when tāngata whaiora have not attended a planned appointment.

Administrators

Provide appropriate administrative support with the sending of correspondence relating to appointments and DNAs as well as the data entry of DNAs into iPM.

2.2 Competency required

Communication skills

2.3 Equipment

- Individual Patient Management (iPM) System
- Clinical Work Station (CWS)
- Microsoft Outlook

2.4 Procedure

Appointment Planning

When arranging appointments with tāngata whaiora, clinicians should collaboratively make appointments with the tāngata whaiora and their whānau – taking into consideration the tāngata whaiora situation, and arrange appointments for days and times that best suit tāngata whaiora and their whanau.

Reminders

Reminding tāngata whaiora of their appointment date and time is a key way to reduce non-attendance at appointments. The tāngata whaiora keyworker is responsible for discussing with them a preferred means of being reminded and then sharing this information with other members of the treating team and documenting this in CWS. The following are current methods of providing appointment reminders:

a) Email (sent from generic mental health & addictions email accessible via admin)

b) Telephone call.

c) Text messaging. An individual text message can be sent to tāngata whaiora through the Outlook email system. These texts are completed independently of iPM and are the clinician's responsibility to initiate, monitor, and record the use of in CWS.

d) Dialhog. These texts are compiled from information on iPM, send out via admin staff.

e) Contact with a whānau member or support person who reminds tāngata whaiora of their appointment. With this arrangement, there needs to be clear documentation in CWS that tāngata whaiora has given consent for another person to be contacted about their appointments.

f) Use of an electronic reminder on the tāngata whaiora mobile phone through an inbuilt diary function or similar.

g) Use of appointment cards and/or letters.

For all types of appointment reminders, the keyworker should discuss with tāngata whaiora their preferred timeframe for receiving a reminder, for example, on the day of the appointment or the day or week before the appointment and then ensure this is factored into any reminder given and clearly documented in CWS.

DNA by Tāngata Whaiora

1. When a tāngata whaiora does not attend a scheduled appointment, an attempt is made to contact them on the day of the appointment by the health professional whom they were to see. If contact is made, the clinician must:
   a) Arrange a further appointment (if indicated)
   b) Discuss the reason/s the tāngata whaiora did not attend the appointment and how these can be mitigated for future appointments.
   c) Gain an understanding of their wellbeing, mental state and risks.
   d) Develop / confirm a collaborative plan to optimise the tāngata whaiora wellbeing and mitigate risks.
   e) The clinician / health professional must document the DNA, reason/s for the DNA including barriers and any mitigations, the mental state and risks and collaborative plan in CWS, and the rearranged appointment.
2. If the attempts to contact the tāngata whaiora are unsuccessful then contact should be attempted via another means, which can include making contact with an identified support person, next of kin, or whānau. If this attempt is successful in making contact with the tāngata whaiora then complete the process as outlined in point 1.
3. If attempts to contact the tāngata whaiora on the day of the appointment are not successful, the non-attendance should be raised as an issue within the treating team as soon as practicable, and decisions made about what to do next. This decision should be driven by what is currently known about the tāngata whaiora in terms of risk, their current pattern of involvement with the service and their mental state. This decision and any actions should be documented in CWS.
4. Further attempts to make contact should be made on the following day/s and alternative means of contact should be utilised, including attempting a home visit.

5. If there continues to be no success in making contact with 10 working days, the situation should again be discussed within the treating team and decisions made about what to do next.
6. If the treating team's decision is that reasonable steps have been taken to make contact with the tāngata whaiora and there are no outstanding clinical concerns then a "14 day" letter should be sent / delivered to the tāngata whaiora informing them that they need to contact their keyworker or the service in the following fortnight or their care will be transferred back to their General Practitioner / medical centre where they have one. Clinicians should continue to attempt to contact the tāngata whaiora during this period. The attempts to make contact and the treating team's decision should be documented in CWS.
7. If there is no contact with the tāngata whaiora within the fortnight following the "14-day" letter being sent, then the transfer back to the care of their GP, where appropriate, should be arranged.

If during this process contact is made with the tāngata whaiora and they indicate that they no longer wish to be seen by the Mental Health and Addictions Service then the clinician should, where possible, ask about the reason/s for tāngata whaiora decision, and gain an understanding of the tāngata whaiora mental state and associated risks. If the clinician(s) deems that the reason/s for discharge are appropriate and that the tāngata whaiora wishes are not a reflection of a deterioration in mental state or an impaired decision-making process then they should inform the tāngata whaiora of the processes involved in transferring their care out of the Mental Health and Addictions Service. This conversation and its outcome should be shared with the treating team and documented in CWS.

Situations involving the Mental Health Act

- For tāngata whaiora who are under the Mental Health Act, the procedure should be followed as described for "Reminders" (points a to f) and "DNA by Tāngata Whaiora" (points 1, 2, 3 & 4). In these situations, discussions about the tāngata whaiora must include the Responsible Clinician and/or Duly Authorised Officer (DAO). Whānau / support people should be consulted where possible.
- If the tāngata whaiora is refusing care and there are concerns that they are mentally disordered and/or a danger to themselves or others, consideration should be given to using the Mental Health Act to facilitate treatment. Discussion(s) must include the Responsible Clinician and/or Duly Authorised Officer (DAO).

Tāngata Whaiora with Repeated Non-Engagement with Services

Repeated non-engagement occurs when a tāngata whaiora has a pattern of non-attendance at prearranged appointments, late cancellations without reason, or limited or no engagement with interventions or activities that are part of their recovery plan. Once this pattern has been identified, a

Recovery Review Meeting should be arranged with the tāngata whaiora, their whānau/support people, and other members of the MDT to understand reasons for repeated non-engagement and develop strategies to improve engagement including:

1. The impact of the tāngata whaioras mental health on engagement in treatment.
2. Fluctuating competence to make decisions around engaging with the service.
3. Mismatches between health professionals and tāngata whaiora around personality, gender, cultural considerations and any other factors.
4. Differences between what is being provided and what the tāngata whaiora would like to be provided.
5. Practical issues such as: transport to appointments, financial barriers, and a lack of immediate contacts or support people to increase attendance and engagement with services.

The Recovery Review Meeting should develop strategies (potentially including the use of the Mental Health Act) to address the challenges causing the non-engagement.

If a decision is made for the tāngata whaiora to have their care transferred out of the Mental Health and Addictions Service then the normal transfer of care process should be followed. This review and its outcomes should be documented in CWS.

3 Patient information

Clinicians ensure Tāngata whaiora and whānau are informed of their rights under the Code of Health and Disability Services Consumer's Rights.

4 Audit

4.1 Indicators

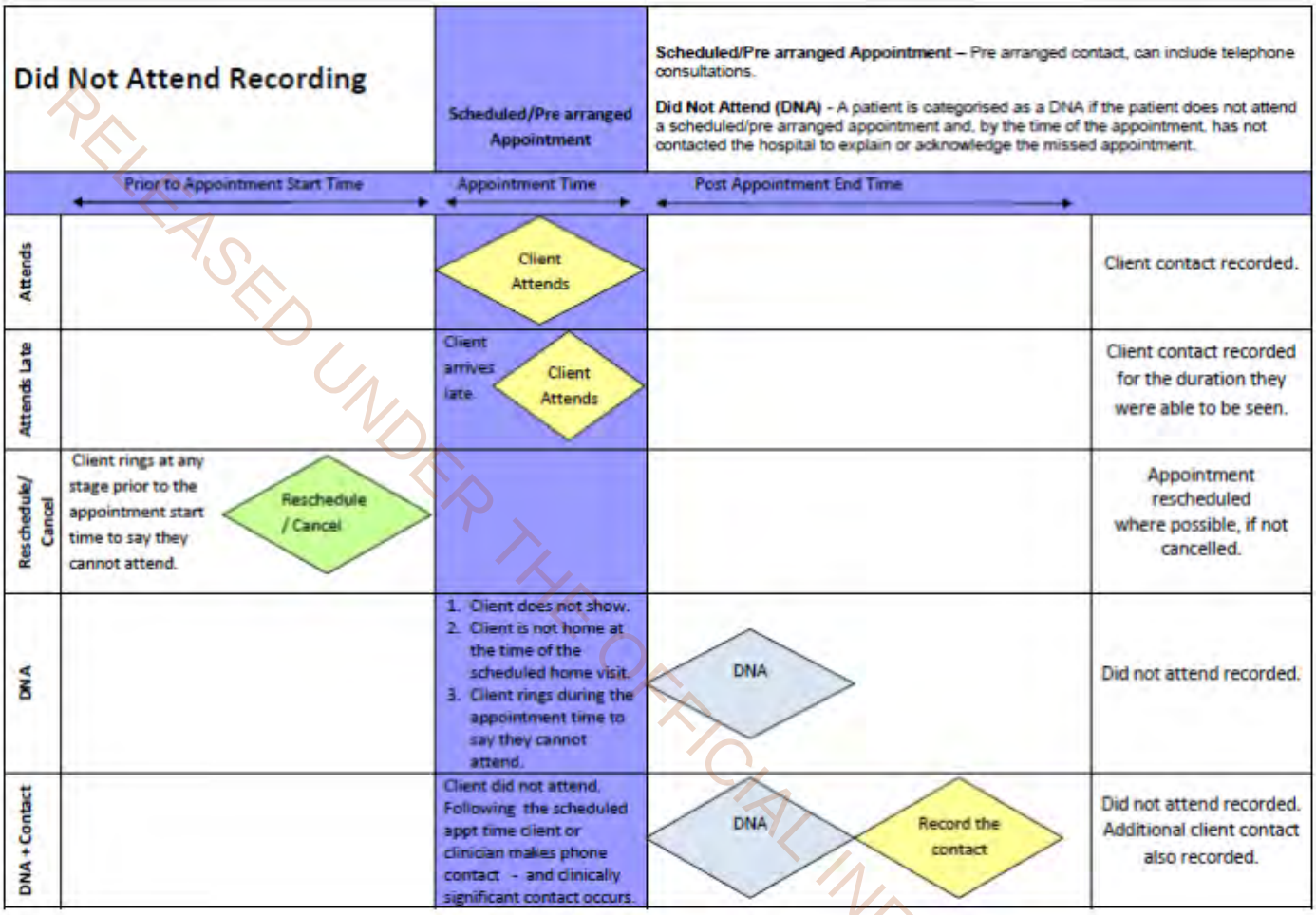
- DNA rates as measured by iPM and included in information presented to monthly Service Clinical Governance Forum
- 6 monthly audit of sample recorded as DNA (taken from Community DNA list, Enterprise Reporting) – reviewing actions taken by clinical teams measured against expectations of the procedure. Feedback given to the teams to identify what is working well and areas for development. Audit results to be presented to service level Clinical Governance forum

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Service Integrated Care Pathway Policy 1703
- Template for the 14 Day letter to the Service User.
- Template of a Transfer of Care letter for the GP.

Appendix A – Guide to recording DNA stats



Assaults or Threats towards Mental Health and Addictions Service staff

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions Service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
04	Rachael Aitchison	July 2015	Inclusion of assault victim complaint guidance
4.1		November 2016	Formatting in appendices corrected
05	Kylie Balzer	May 2020	Inclusion of flow chart for process
06	Kylie Balzer	October 2023	Flow chart changed to table of actions to be completed Inclusion of additional support options for staff

Assaults or Threats towards Mental Health and Addictions Service staff

Contents

Assaults or Threats towards Mental Health and Addictions Service staff

1 Overview

1.1 Purpose

The purpose of this procedure is to ensure that all assaults or threats to staff are addressed promptly and in a way which supports the complainant. It also outlines a process for making a complaint which staff should follow if they are assaulted by a tāngata whaiora or other person within the practice environment.

1.2 Staff group

This procedure applies to all assaults or threats made towards any Mental Health and Addictions staff member.

1.3 Patient / client group

Mental Health and Addictions tāngata whaiora and staff.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

Assault	Means "the act of intentionally applying or attempting to apply force to the person of another, directly or indirectly, or threatening by any act or gesture to apply such force to the person of another, if the person making the threat has, or, causes the other to believe on reasonable grounds that he / she has present ability to effect his purpose" Crimes Act 1961

2 Clinical management

2.1 Roles and responsibilities

All Staff
Completion of incident notification and a witness statement

Managers
Follow up of the incident and implementation of actions in response to any identified learnings.

2.2 Competency required

- Incident notification and review
- Completion of witness statement

2.3 Equipment

- Clinical record
- Employee Assistance Programme Information
- DATIX incident reporting system
- Emergency trolley if assessed as necessary
- Te Whatu Ora Waikato Wellbeing Intranet page

2.4 Procedure

All assaults are a serious matter, and depending on the seriousness of the assault, these matters need to be escalated and managed appropriately. The below aligns with the current SAC assessment criteria: corporate consequence for staff / contractor / visitor utilised within our work place.

Severe	Major	Moderate	Minor	Minimal
SAC 1	SAC 2	SAC 3	SAC 4	
Death(s) of staff member contractor or visitor	Permanent disability or loss of function to staff member, contractor or visitor; requires major additional medical or surgical intervention Notifiable to Worksafe	Staff member, contractor or visitor requires extended treatment	Staff member, contractor or visitor requires short term treatment only with no lost time or restricted duties	Staff member, contractor or visitor requires nil or first aid treatment only

Assault/threat occurs
Ensure all people involved in the incident are supported appropriately, this may include; • Removed from the situation • Defusion • Supported to receive medical attention • Emotional support • Spiritual support • Employee Assistance Programme (EAP) or Critical Incident Support for staff Tāngata whaiora who has allegedly assaulted the staff member is managed appropriately, which may include but not be limited to: • Removing the person from the situation/area • Having time out in a low stimulus environment • PRN medication • Medical review (management plan) • Assault is clearly documented in clinical work station (use a separate progress note to highlight this). • Update risk tool • Complete a Datix incident notification (even if no injuries are evident). • Police complaint reference/ job number – obtain this after reporting assault to police, and document number in progress notes.

Assaults or Threats towards Mental Health and Addictions Service staff

Leadership team to be informed of assault (if after hours, Co-ordinator to be informed) and support staff/victims to escalate as per below:

SAC 1 or 2

1. Treating team is to be contacted **immediately** (If after hours on duty SMO).
2. A review needs to be conducted alongside a management plan that identifies if escalation of the event to police via calling 111 is required.
3. Staff supported to report the event, clearly stating assault and that it occurred at the 'name the site' e.g. Henry Rongomau Bennett Centre (HRBC)/London St and document file number for the complaint in clinical work station.
4. Email to be formatted to leadership team, including operations manager informing them of the serious assault. A phone call may be more appropriate, depending on the seriousness of the assault.

For a serious assault police would attend to take the appropriate statements.

SAC 3 or 4

1. Treating team to be contacted as soon as practicable
2. Staff supported to complete online report via: 105 Police Non-Emergency website **https://www.police.govt.nz/use-105#online-report-options**
3. When completing the online report ensure that you have the following information:
   - Tāngata whaiora name (alleged offender), date of birth and NHI
   - Identify the date and time of the assault
   - Clearly identify the victim and witnesses to the assault including the witnesses' name, date of birth and contact details.
   - Document the:
     - Circumstances leading to the assault
     - What happened in the incident
     - What happened after the incident

     Be as specific as possible about any harm arising from the assault e.g. blood nose, black eye
4. It is recommended that the clinician take notes on the incident as the police may request a further statement at a later date.
5. You will be emailed conformation and acknowledgement of your online report.
6. Forward email of confirmation and acknowledgement of your online report to your ward leadership team

Datix incident notification completed.

Assault is clearly documented in clinical work station (use a separate progress note to highlight this) including police complaint reference/ job number after calling 111 OR file number from 105 report, datix number

The leadership team are to forward all file numbers to the respective operations managers. Operation Manager is to forward file number to the police liaison contact person
All assaults will be discussed and progress will be reviewed at the bi-monthly police liaison meeting. Feedback of the progress of the complaints will be provided to the complainant/s and the respective manager/s via the operations manager.

If the assault incident involved tāngata whaiora the DATIX number for the incident will be included in the clinical record.

3 Staff follow up

Ensure staff member is supported appropriately, which may include:

- Defusion (immediate small group support)
- Check in on staff member and offer quite space and/or time off the ward
- Debrief
- Support to receive medical attention
- Emotional support
- Employee Assistance Programme (EAP)
- Time off the ward/away from the situation to support self-regulation
- Request for Critical Incident Support (can be accessed through intranet on Wellbeing Oranga Kaimahi page). Wellbeing (health.govt.nz)
- Support to connect to a workplace support person
- Chaplaincy services
- Kaitakawaenga support

Leadership follow up should include:

- After event check in on staff member offer quite space off the ward
- After event check in with staff on duty at the time of the event
- Arrange a phone call to staff member
- Arrange welfare check
- If applicable explore leave options with staff
- Update staff member of outcome from assault (i.e. complaint laid with police)
- Inform staff that they will also receive a phone call from Human resources to follow up with incident.

Maintaining healthy work environment

- Arrange regular ward wellbeing catch up
- Support staff to access wellbeing resources
- Arrange return to work plan

4 Audit

4.1 Indicators

- Assaults or threats to staff are addressed promptly and in a way which supports the complainant.
- Assaults are discussed at the bi-monthly police liaison meeting.

4.2 Tools

- Incident follow up.

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

- McKenna B., Poole, S., Smith. N, Coverdale, J. & Gale, C. (2003). A survey of threats and violent behaviour by patients against registered nurses in his / her first year of practice. *International Journal of Mental Health Nursing.* Volume 12, Issue 1. Page 56.
- Nice Guideline UK www.nice.org.uk/guidance/NG10

5.2 Associated Te Whatu Ora Waikato Documents

- Critical Incident Management for Staff policy (Ref. 0175)
- Employee Assistance policy (Ref. 0286)
- Harassment and Bullying policy (Ref. 1963)
- Incident Management policy (Ref. 0104)
- Notifiable Events Management policy (Ref. 0074)
- Treating Staff Injured at Work guideline (Ref. 1515)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (Ref. 5241)

5.3 External Standards

- Health and Safety at Work Act 2015
- Human Rights Act 1993
- Privacy Act 2020
- Employee Relations Act 2000
- Treaty of Waitangi Act 1975
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Crimes Act 1961

AWOL (Absent Without Official Leave)

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions Service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health an Addictions Service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
07	Kylie Balzer	November 2022	Updated into current Te Whatu Ora procedure template
06	Kylie Balzer	October 2019	Updated into current DHB procedure template Inclusion of flow charts
5.1	Kylie Balzer Inpatient Operations Manager	August 2016	Printshop document number for Mental Health and Addictions Missing Persons Checklist A7134HWF
5.1	Kylie Balzer Inpatient Operations Manager; Louise Quinn Clinical Nurse Specialist	July 2016	Update to checklist and requirements to upload to clinical workstation (CWS) Inclusion of information that security is only involved for on hospital campus incidents Update to incident information related to introduction of DATIX risk management system Inclusion of service users on Section 31 Leave
05	Mental Health, Security Manager, Police representative	May 2015	Service wide procedure for AWOL response; inclusion of response based on risk category for Mental Health and Addictions service and policy; AWOL minimisation strategies; tools for staff use

AWOL (Absent Without Official Leave)

Contents

AWOL (Absent Without Official Leave)

1 Overview

1.1 Purpose

This procedure specifies Te Whatu Ora Waikato standards for the management of AWOL from hospital and community settings within the provision of Mental Health and Addictions services within Te Whatu Waikato.

This procedure is intended to provide clear direction of the steps to take when a tāngata whaiora is AWOL. It also provides the steps to take when a tāngata whaiora returns to the treatment setting.

This procedure will assist with determining the level of risk for the person or others and the appropriate response and management of their absence and / or return to the treatment setting.

1.2 Staff group

This procedure is applicable to all clinical staff, managers, and security staff at Te Whatu Ora Waikato.

1.3 Patient / client group

This procedure applies to all Mental Health and Addictions inpatients in a hospital setting that are AWOL, and to tāngata whaiora under compulsory processes who are absent without authorisation from specified community placements within Te Whatu Ora Waikato. This is inclusive of tāngata whaiora on Section 31 leave from inpatient services.

1.4 Exceptions / contraindications

Informal tāngata whaiora who discharge against medical advice and **are not deemed** to be medically, psychologically, or physically at risk of harm to themselves or others are exempt from this procedure. If at any time the risk to the tāngata whaiora changes the AWOL procedure is to be initiated.

1.5 Definitions and acronyms

AWOL (Absent Without Official Leave)	This term applies to a tāngata whaiora who is unable to be located within the service area and who has not had a planned transfer to another area for treatment or investigation and has been assessed as medically, psychologically, or physically at risk of harm to themselves or others. The term applies for Mental Health clients when a tāngata whaiora (including Special Patient) under compulsory processes absent themselves without authorisation from an inpatient unit or from a specified community placement. This includes when the tāngata whaiora leaves an escort or does not return from a period of specified leave.
Code Red	Immediate security response which includes searching the hospital grounds

Informal	Tāngata whaiora who are inpatients on a voluntary basis, not admitted under the mental health act, and not legally obliged to be on the unit
	Categories for AWOL
Category A (High Risk)	Any tāngata whaiora considered to be a serious or imminent risk to self, identified other(s) or to property A tāngata whaiora assessed to be no immediate risk to self, identified other(s) or property but whose risk increases if they fail to take prescribed medication; alcohol or illegal drugs; or are exposed to circumstances which may trigger a psychotic response putting themselves or others at risk due to past noted risk behaviour in these circumstances. **Note:** Tāngata whaiora who are categorised as a Special or Restricted patient as defined by the Mental Health Act, who are absent without leave or clinical authority are automatically Category A.
Category B (Moderate Risk)	A tāngata whaiora assessed to be no immediate risk to self, identified other(s) or property but whose risk increases if they fail to take prescribed medication; alcohol or illegal drugs; or are exposed to circumstances which may trigger a psychotic response putting themselves or others at risk due to past noted risk behaviour in these circumstances. **Note:** All tāngata whaiora absent without authority from a Mental Health inpatient unit would normally be categorised as either Category A or B.

2 Clinical management

2.1 Roles and responsibilities

All Clinical Staff

- Making adequate and appropriate assessment and documentation of risk
- Ensuring any absences from the usual treatment setting are authorised in accordance with the requirements of the Mental Health Compulsory Assessment and Treatment Act and the documentation of any terms and conditions.
- Notification of any Absent Without Official Leave (AWOL) to senior registered health professional
- Ensure every attempt is made for the safe return as soon as is practicably possible of tāngata whaiora under their care
- Staff who provide support to security in a search for tāngata whaiora must work under the direction of security personnel. At all times staff must be aware of maintaining their own health and safety.

Senior Nursing Staff / Senior Registered health professional

- The senior nurse / team leader on shift is responsible for:
  - scanning the NZ police missing person report to the police and ensuring a response is received
  - oversight of any missing person event

- formatting and forwarding email to the senior leadership team (CNM, Operations Manager, Director, Clinical Director)
- ensuring the next of kin, principle caregiver or other named contact person is advised of the tāngata whaiora absence. Regular contact with the whānau should occur with updates as agreed with the whānau key contact person.

Managers

- Review and monitor AWOL incidents.
- Post incident support to tāngata whaiora; whānau; staff as appropriate to the context.
- Refer any publicity surrounding a missing tāngata whaiora to the Clinical Services Director in consultation with the executive leadership team.
- Monitor the audit criteria and manage practice changes required.

Security staff

- Security staff are responsible for coordinating the search of the hospital campus.

2.2 Competency required

All clinical staff and security staff must be informed of the AWOL procedure during their orientation / induction to the organisation.

This procedure is carried out by the Charge Nurse Manager / Associate Charge Nurse Manager / Team Leader.

Staff required to be in the Incident Controller role must receive training in their role as an incident controller.

2.3 Equipment

- New Zealand Missing Person's Report
- Risk assessment and formulation – Mental Health and Addictions service
- Clinical record
- Leave management plan – Mental Health and Addictions service
- Mental Health and Addictions Service Missing Persons checklist A7134HWF

2.4 Procedure

Staff responsibilities regarding tāngata whaiora location in the hospital setting

Ward / unit staff are responsible for knowing the whereabouts of tāngata whaiora they are responsible for at all times. To assist knowledge of where the tāngata whaiora is, staff actions may include and are not limited to the following:

- Accurately and timely update of the Client Information System (IPM) and ward unit tāngata whaiora tracking system (whiteboard)

- Notifying the staff member responsible for the tāngata whaiora of appointments – clarify if they were meant to be away from the ward / department and when they are expected to return
- Providing information to informal tāngata whaiora to communicate with staff if they are leaving the ward / unit for any reason and to give an expected time of return
- Ensure documentation and verbal handover / transfer of care of tāngata whaiora include:
  - Details relevant to tāngata whaiora that are subject to the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 or the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Criminal Procedure (Mentally Impaired Persons) Act 2003 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
  - The security rating for any tāngata whaiora (Category A or B)
- Communicating with tāngata whaiora and whānau on the importance of being present for prescribed treatments so as not to cause any delay in their recovery programme as a result of not being present on the ward
- Educating that smoking may only occur within the requirements of the Te Whatu Ora Smokefree Auahi Kore Vapefree Rehuwai Kore Policy (0121)
- Communicating with whānau / visitors the reasons for and importance of talking with staff prior to tāngata whaiora leaving the ward.

Risk assessment

A current risk assessment must be completed by the clinical team responsible for the tāngata whaiora and must be communicated to the response team, police, security officers and others involved in searching for the person. A risk assessment is based on the clinical and psychological state of the tāngata whaiora and must include:

- Is the tāngata whaiora a risk to themselves?
- Is the tāngata whaiora a risk to others?
- Is the tāngata whaiora at risk of harm from others?
- If the tāngata whaiora condition is likely to deteriorate and what timeframe is this likely to occur in

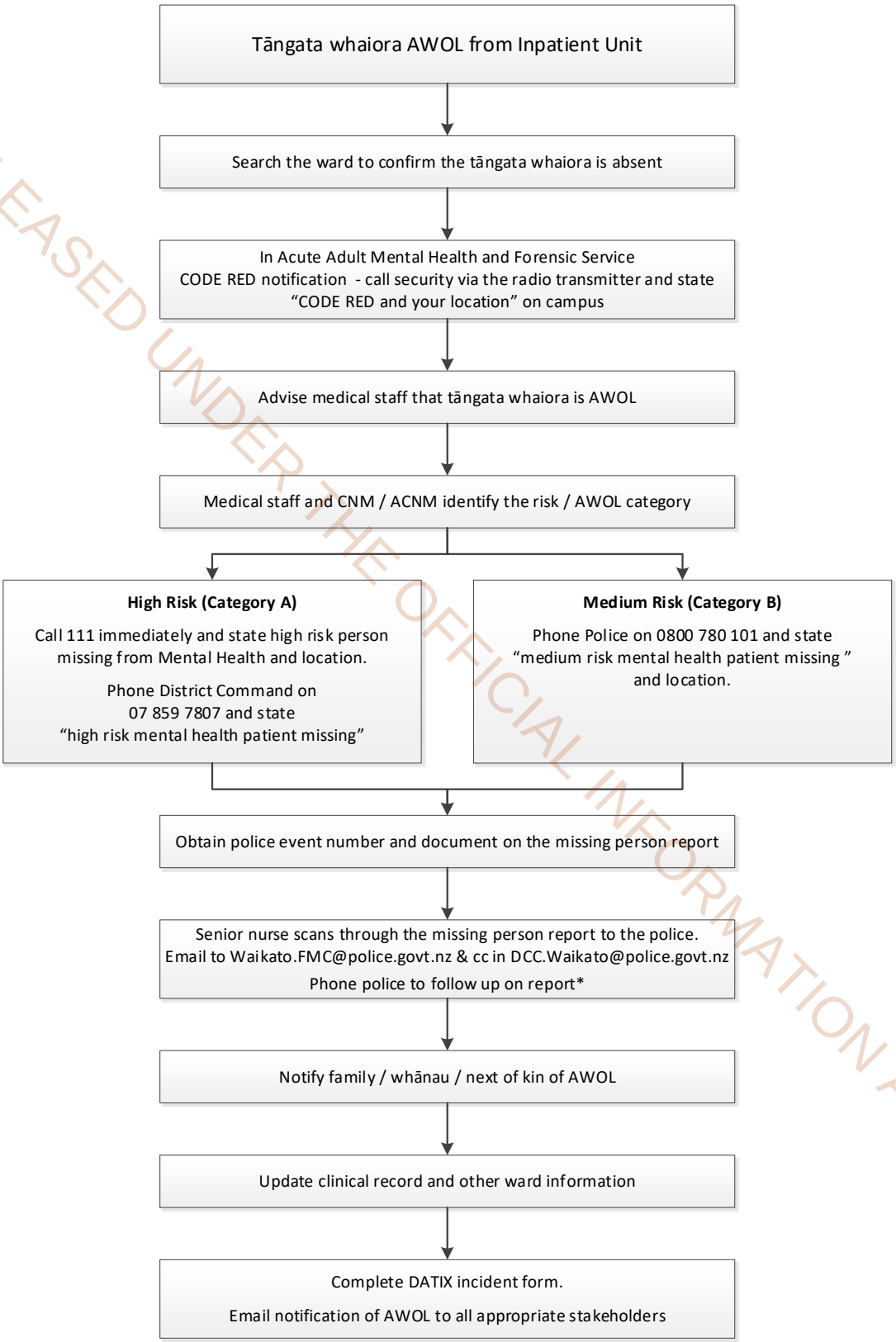
Note when notifying police of the risk: Between the hours of 2200hrs and 0600hrs the email address WaikatoFMC@police.govt.nz is not monitored. Therefore **it is imperative that staff make the 0800 780 101 phone call in the first instance.**

For police response to AWOL categories see appendices.

AWOL (Absent Without Official Leave)

Staff responsibilities regarding reporting and management of AWOL

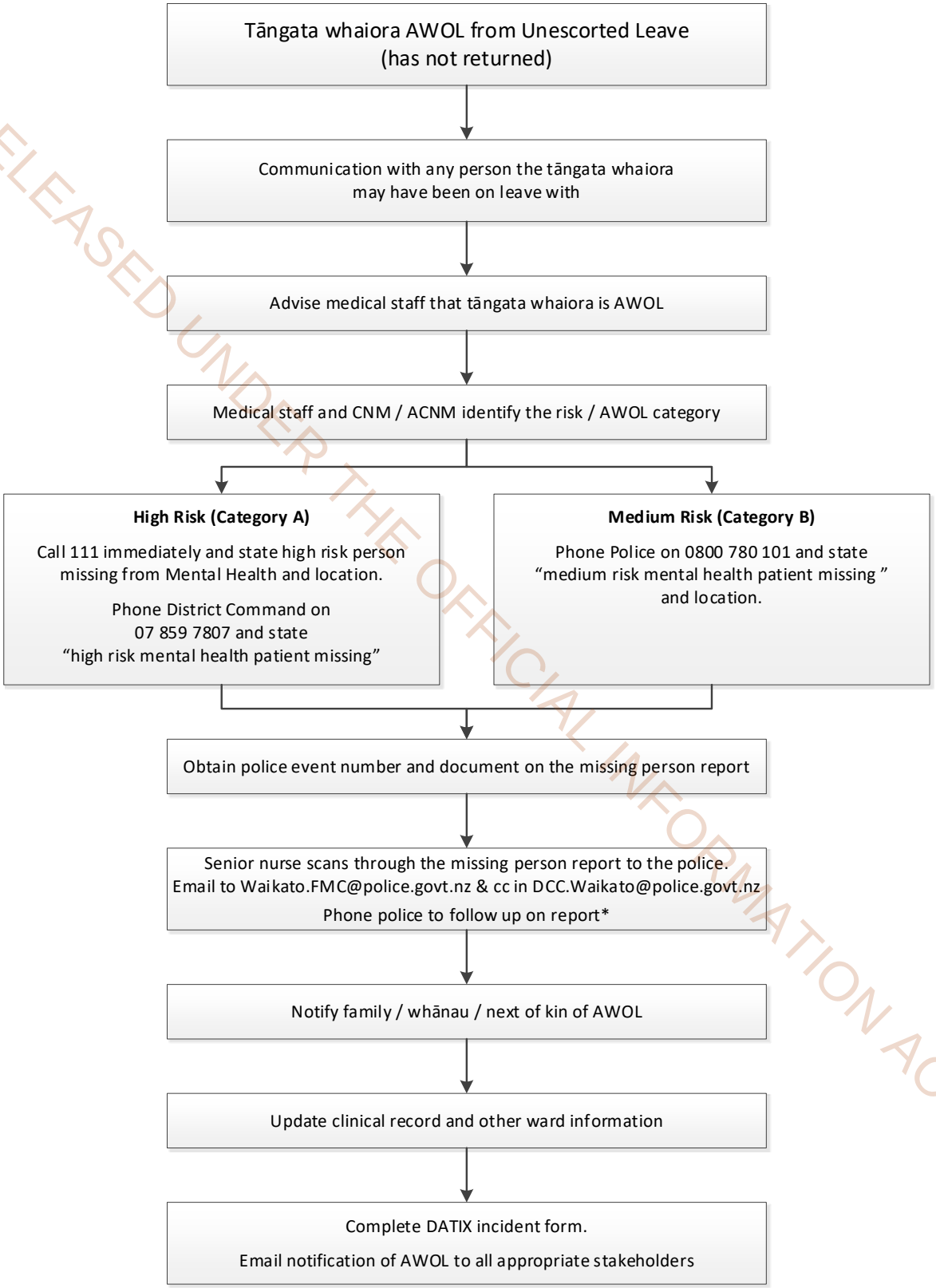
If tāngata whaiora is not observed in the inpatient unit:



* Between the hours of 2200hrs and 0600hrs, the email address Waikato.FMC@police.govt.nz is not monitored.

AWOL (Absent Without Official Leave)

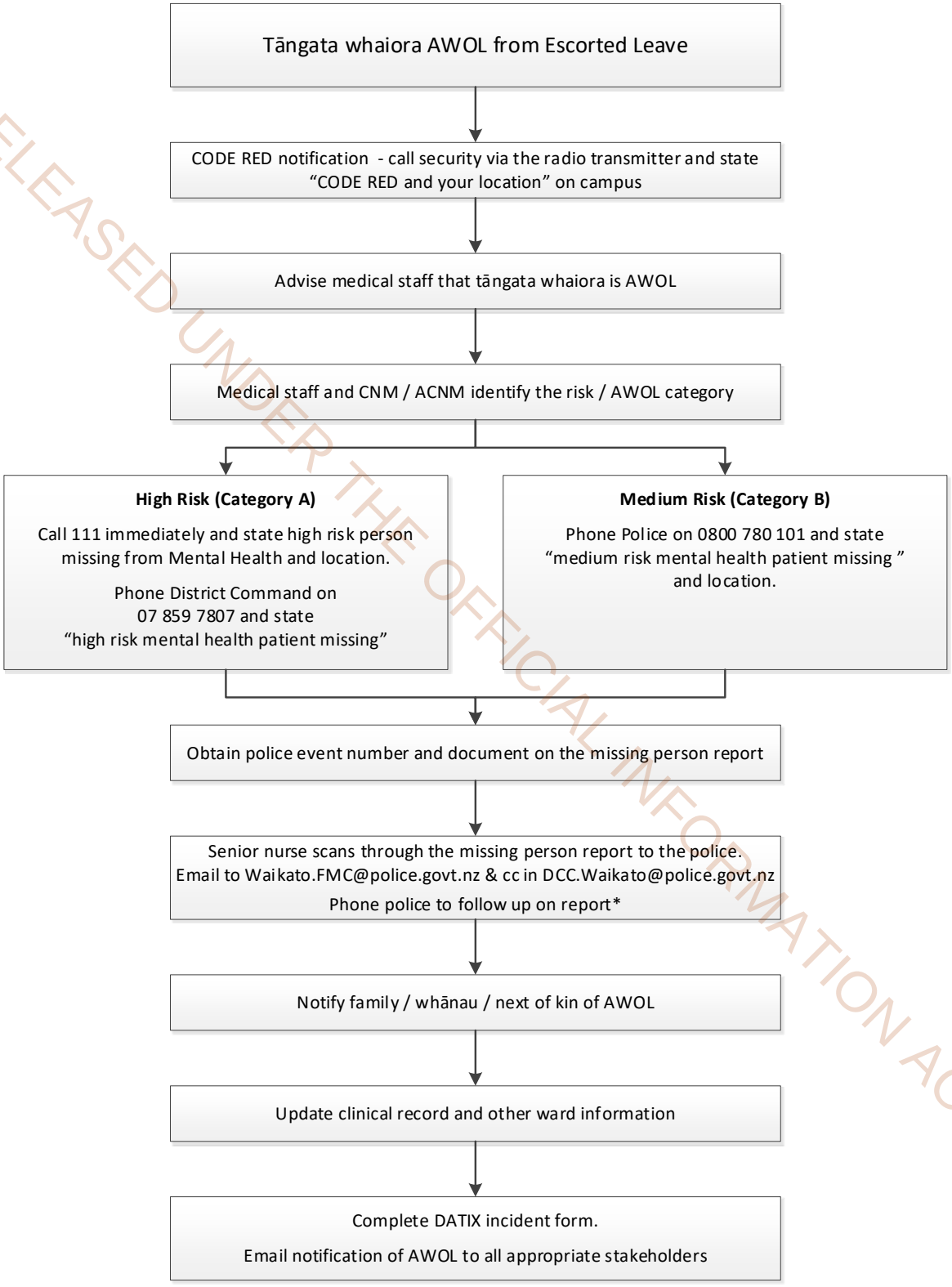
If tāngata whaiora has not returned from unescorted leave:



* Between the hours of 2200hrs and 0600hrs, the email address Waikato.FMC@police.govt.nz is not monitored.

AWOL (Absent Without Official Leave)

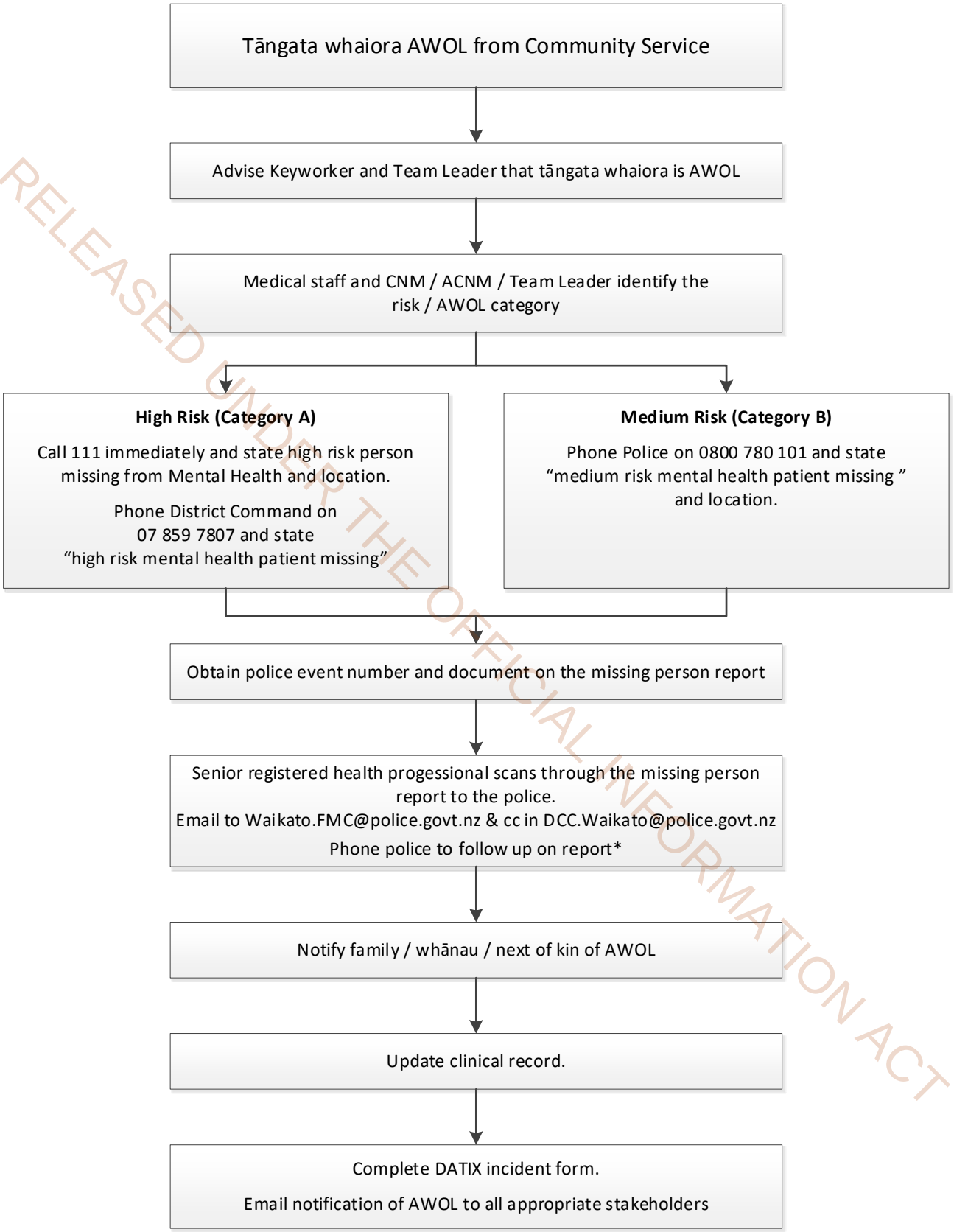
If the tāngata whaiora absconds whilst on escorted leave:



* Between the hours of 2200hrs and 0600hrs, the email address Waikato.FMC@police.govt.nz is not monitored.

Staff responsibilities regarding tāngata whaiora location in the community setting
In the Community Mental Health setting the risk to the tāngata whaiora must be identified and the level of response to the identified risk initiated by the team leader or delegate.
For processes in response to a tāngata whaiora who does not attend a pre-arranged appointment refer to the Mental Health and Addictions Appointment Planning and Did Not Attend Management with Tāngata Whaiora procedure (0900).

AWOL (Absent Without Official Leave)



* Between the hours of 2200hrs and 0600hrs, the email address Waikato.FMC@police.govt.nz is not monitored.

2.5 Communication with other personnel

- Advise treating team that tāngata whaiora is AWOL
- After Hours inform the appropriate on call Registrar / Consultant
- Notify the Crisis Assessment and Home Based Treatment Team by phone and scan a copy of the Missing Person report to CAHT.MHAS@waikatodhb.health.nz
- If a potential person at risk is known (registered victim) follow the Forensic Service registered victim process
- Ensure community Keyworker is informed.

2.6 Communication with whānau

The Senior Nurse / Team Leader (Incident Controller) is responsible for ensuring the next of kin, principle caregiver or other named contact person is advised of the tāngata whaiora absence. Communication with the whānau is to be documented in the clinical record and Mental Health missing person checklist. Regular contact appropriate to the individual context with the whānau should occur with updates as agreed with the whānau key contact person.

2.7 Handover process

If the senior nurse facilitating the event during a shift is required to be absent from the ward a full handover of what has happened, and next planned actions must be provided to the senior nurse / team leader taking over the responsibility. This will involve going through the missing person's checklist.

If a tāngata whaiora remains AWOL after the time the senior nurse coordinating the event has completed their shift the missing person event must be handed over to the senior nurse on shift for the Bureau.

A handover will involve a verbal and written update (Missing Person Checklist) of all actions taken, and the plan of actions to be taken for this tāngata whaiora. The senior nurse from the Bureau receiving the responsibility for the facilitation of the missing person's event will sign the Missing Person's checklist. The signature of the senior nurse will confirm that they have received all necessary information to enable them to facilitate the event going forward.

2.8 On return of tāngata whaiora

It is the duty of Te Whatu Ora Waikato to arrange return of tāngata whaiora who are absent without leave. However, any such tāngata whaiora who are located by the Police and are willing to return may be returned by the Police.

Where a Mental Health tāngata whaiora refuses to return with the Police the Police will refer the matter to a Duly Authorised Officer. Where necessary and when requested, the Police will assist the Duly Authorised Officer to return the tāngata whaiora to the hospital

The Mental Health service may make a request of the DAMHS to apply at the District Court for a warrant that authorises any constable to take a proposed patient or patient under the MH (CAT) Act 1992 to the place specified in the warrant. This process can be initiated for a patient or proposed patient who is (a) refusing to attend at a place at which he / she is required to attend; (b) absent from the hospital without leave, or; (c) when the leave of absence has expired or has been cancelled. This application of warrants should not ordinarily be considered for patients whose whereabouts are unknown, as these patients can be reported to the police as a missing person of interest to mental health services (as in the process above) with clear directions provided to police regarding the required actions to facilitate assessment when the person is located, including taking that person to a place for assessment as directed by a DAO under Sec41 MH (CAT) Act.

The DAO may issue instructions to the police as per SS40/41 of the MH Act

On return of the tāngata whaiora it is important that the people notified in the AWOL process are notified including the police and whānau, providing information as appropriate to the context.

Following an AWOL the following should occur:

- Ensure the environment and levels of observation are appropriate to the tāngata whaiora current context
- Update clinical risk assessment and documentation
- Review of the tāngata whaiora recovery plan
- Ensure AWOL is included in multidisciplinary team discussion and development of treatment plan

3 Patient information

- Mental Health and Addictions Service Information for tāngata whaiora
- Mental Health and Addictions Service Information for whānau / friends

4 Audit

4.1 Indicators

- Incident management reviews demonstrate consideration as to why the AWOL event may have occurred, and strategies aimed at reducing AWOL incidences.
- Missing person checklist demonstrates that the AWOL procedure has been followed

4.2 Tools

- Quarterly review of AWOL incidents by service level clinical governance forums
- Mental Health AWOL audit tool

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

- Counties Manukau DHB AWOL (Absent without official leave) or Absences causing concern Policy Version 3.0 and procedure Version 1.0
- Patel, S. (2014). A review of AWOL policy in use across London; a case for greater standardisation. *Mental Health Review Journal,* 19, (3), 156- 162
- The Patient Safety Education Program Canada Module 13b Mental Health Care: preventing and responding to absconding and missing patients. http://www.patientsafetyinstitute.ca/6C35CF25-F88F-47CC-9564-EE55E7426E1E/FinalDownload/DownloadId-31C41CB3F06C7D0E7DFD18EC911A7A3E/6C35CF25-F88F-47CC-9564-EE55E7426E1E/english/education/patientsafetyeducationproject/patientsafetyeducationcurriculum/mentalhealthmodules/documents/module%2013b%20absconding%20and%20missing%20patients.pdf. Accessed 3 June 2015

5.2 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Service Missing Person Checklist A7134HWF
- Waiora Waikato Campus Emergency Incident Response
- Mental Health and Addictions Appointment Planning and the Management of DNA's with Tāngata Whaiora procedure (0900)
- Mental Health and Addictions Duress alarm use and management inpatient Mental Health and Addictions procedure (2681)
- Mental Health and Addictions Leave status and its Application procedure (2184)
- Mental Health and Addictions Levels of Observation Inpatient Services procedure (5238)
- Mental Health and Addictions Working with Risk: Assessment and intervention to tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Emergency Flip Chart Processes (99777 flip chart in all staff areas)
- Restraint policy (2162) and procedures
- Smokefree Auahi Kore Vapefree Rehuwai Kore policy (0121)
- Incident Management policy (0104)

5.3 External Standards

Te Whatu Ora Waikato Mental Health and Addictions service is required to meet and comply with the following legislation (this list is not exclusive):

- Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Code of Health and Disability Services Consumers' Rights Act 1994
- Crimes Act 1961
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Health and Disability Sector Standards NZS8134:2021
- Health and Disability Consumer Rights Act 1994
- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003
- Land Transport Act 1998
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998
- Misuse of Drugs 1975 – section 24
- Protection of Personal and Property Rights Act 1988
- Victims' Rights Act 2002
- Health and Safety at Work Act 2015
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1975

Appendix A

Police response to categories of AWOL / Absences Causing Concern

Note: The Police use a process of prioritisation for notifications which defines their level of response **Police code: 2M** • Person entered on Police Computer systems as "Missing" • Any persons thought to be at risk of serious harm from the missing patient are to be notified and if necessary moved to safe locations • File assigned for immediate enquiries to be made at any known addresses / locations • Person's details / description subject to media release
Police code: 2M • Person entered on police computer system as "Missing" • File assigned for enquiries to be made at any known addresses / locations when time allows • Return to Mental Health facility by police if located, or if refusal, attendance by a Duly Authorised Officer. (Note: The police are required to look for the person and if they come to the attention of the police then an alert will be on the system) • File held in Enquiry Office until person has been located, or if refusal, attendance by a Duly Authorised Officer • File held in Enquiry Office until person has been located or Treatment Order expires
Police code: No 2Z • Person entered onto police computer system with alert only • Person returned to Mental Health facility if located

BAO "Be aware of" – Crisis Assessment and Treatment Service

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Ellyn Gooding
Document Facilitator Title	Charge Nurse Manager CAHT
Document Owner Name	Rees Tapsell
Document Owner Title	Director Clinical Services
Target Audience	Mental Health and Addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
2	Glen Horrack	December 2015	Change from Crisis Assessment Team to Crisis Assessment and Home Treatment Team and change from CRV Clinical Results Viewer to CWS Clinical Workstation
3	Glen Horrack	March 2019	Removal of reference to a hard copy file Update to flow chart
4	Glen Horrack	March 2022	Updates to terminology Removal of faxing

BAO "Be aware of" – Crisis Assessment and Treatment Service

Contents

BAO "Be aware of" – Crisis Assessment and Treatment Service

1 Overview

1.1 Purpose

To ensure one standard process of alerting CAHT to tāngata whaiora at risk: including suggested actions / considerations if that person were to come to the attention of the service outside of working hours.

1.2 Staff group

BAO alerts are accepted from all Te Whatu Ora Waikato services, including inpatient services for clients 'AWOL (Absence Without Official Leave)' and on 'short term leave'. BAO alerts are also accepted from all other services, including NGO providers and other Districts.

1.3 Patient / client group

This procedure relates to tāngata whaiora with risk who are not requiring active follow up.

1.4 Exceptions / contraindications

This procedure does not apply to tāngata whaiora requiring active follow up.

1.5 Definitions and acronyms

BAO	'Be aware of' – the process for alerting the Crisis Assessment and Home Treatment team to tāngata whaiora at risk
CAHT	Crisis Assessment and Home Treatment team

2 Clinical management

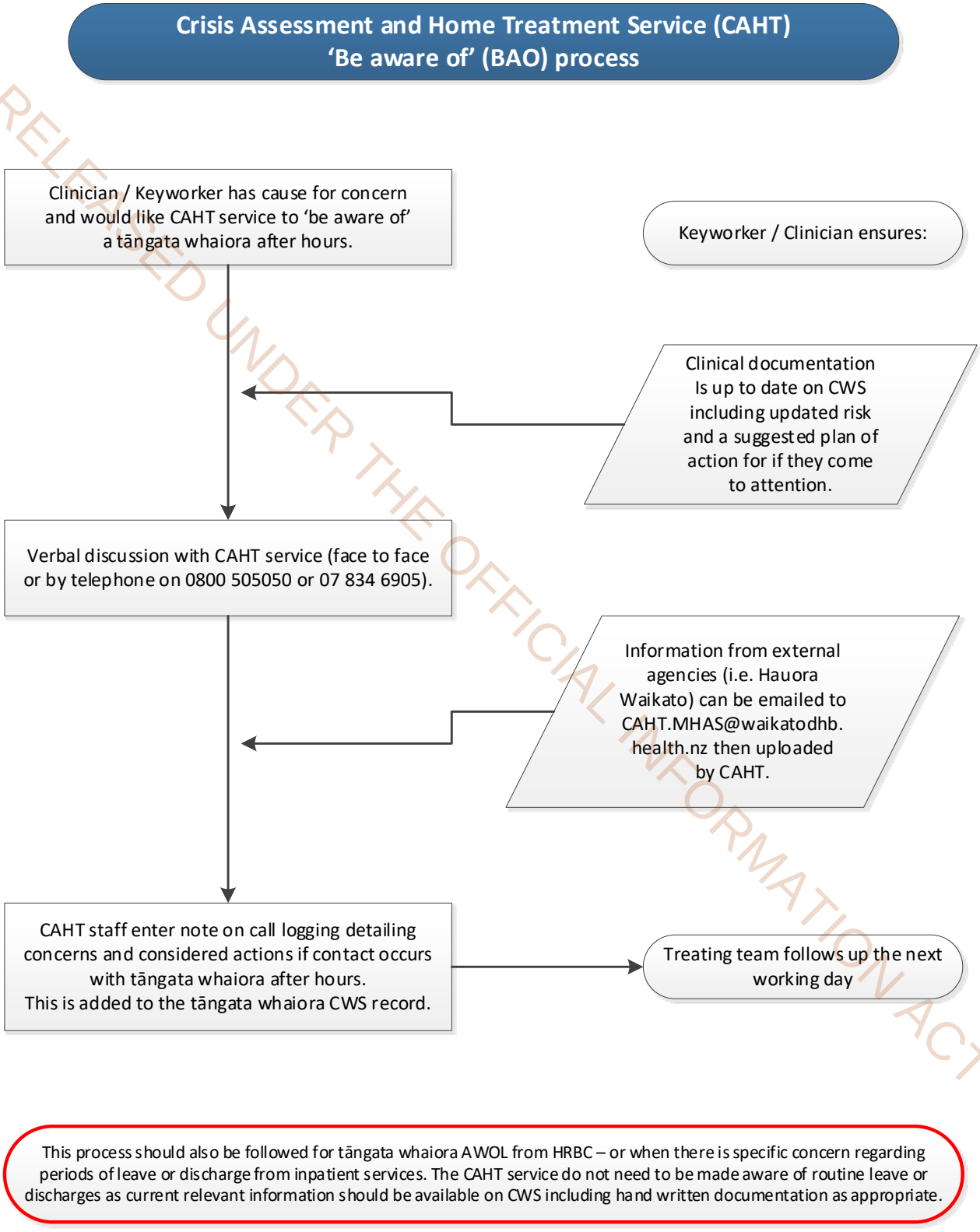
2.1 Competency required

All Mental Health and Addictions clinical staff must be informed of the BAO "Be aware of" Crisis Assessment and Treatment service procedure during their orientation / induction.

2.2 Equipment

- Phone
- Clinical Workstation

2.3 Procedure



3 Patient information

Nil

4 Audit

4.1 Indicators

- Tāngata whaiora 'AWOL (Absence Without Official Leave) 'or on leave where there is cause for concern are communicated to the Crisis Assessment and Home Treatment team (CAHT).

4.2 Tools

- Reviews of incidents show that the BAO procedure was utilised when appropriate.

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health AWOL (Absent Without Official Leave) procedure (Ref. 3555)
- Mental Health Leave – Adult Mental Health Inpatient Wards procedure (Ref. 2184)
- Mental Health Requests for weekend physical monitoring of service users commencing Clozapine treatment procedure (Ref. 2713)

Bedroom Access for tāngata whaiora – Puna Awhi-rua and Puna Maatai

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions Service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Peter Dean
Document Owner Title	Clinical Director Forensics
Target Audience	Forensic service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
07	Charge Nurse Managers: Andrew Evans; Alan Barlow	March 2015	Changes to action on observations; inclusion of audit criteria and information for service users
08	Kylie Balzer	May 2018	RESPECT training changed to SPEC training Roles and responsibilities added Audit indicator added – daily duty allocations
09	Kylie Balzer	March 2021 September 2021	Update to use of 'tāngata whaiora' Changes arising from feedback from staff consultation Changed from action rationale format as this is no longer accepted by the Quality and Patient Safety service

Bedroom Access for tāngata whaiora – Puna Awhi-rua and Puna Maatai

Contents

Bedroom Access for tāngata whaiora – Puna Awhi-rua and Puna Maatai

1 Overview

1.1 Purpose

Procedure for staff to facilitate tāngata whaiora access to their bedroom areas whilst an inpatient in Puna Awhi-rua and Puna Maatai.

Bedroom access is provided for the following reasons:

- To enable attention to Activities of Daily Living (ADLs) at various times of the day, introducing some flexibility into the structured / secure environment
- To provide a period of 'quiet time' enabling tāngata whaiora to have time to self / privacy / rest and assist in maintaining the therapeutic milieu
- Sleeping purposes

1.2 Scope

This procedure applies in the following Forensic inpatient wards: Puna Awhi-rua and Puna Maatai.

1.3 Patient / client group

Forensic tāngata whaiora in Puna Awhi-rua and Puna Maatai.

1.4 Exceptions / contraindications

Nil.

1.5 Definitions and acronyms

General bedroom access	Tāngata whaiora in Puna Awhi-rua and Puna Maatai can access their bedrooms without restriction at specific times as documented in each ward area and dependent on meal times, weekday or weekends and whether the therapeutic programme is in progress.
SPEC	Safe Practice and Effective Communication Training

2 Clinical management

2.1 Roles and responsibilities

All Staff
Must follow this procedure, and safety requirements

Clinical staff
Must meet the requirements of the Levels of Observation Across all Mental Health and Addictions Inpatient Services procedure (5238).

Managers
The Charge Nurse Manager must ensure compliance with this procedure is audited.

Contractors
Must only enter ward and bedroom areas under the guidance of Forensic staff.

2.2 Competency required

- Levels of observation across all mental health and addictions inpatient services on line training is completed.
- SPEC training.

2.3 Equipment

Duress alarm

2.4 Procedure

2.4.1 Observation

During periods of bedroom access a staff member will be allocated to observe tāngata whaiora activities within bedrooms and the bedroom corridor. This is to maintain the safety of the tāngata whaiora; ensure tāngata whaiora do not enter each other's rooms; and to ensure the bedroom area remains a restful / quiet environment.

To maintain observation and safety of tāngata whaiora the observing staff member on Puna Maatai and Puna Awhi-rua is to position themselves at the lounge end of the corridor throughout the period of observation.

Presence of tāngata whaiora in the bedroom corridor is documented on the whiteboard and removed when the person is out of the bedroom area.

2.4.2 Levels of observation

Checks must be made on every tāngata whaiora during all periods of bedroom access by the staff member assigned to the observation checks, as per the individual's level of observation and supported by the staff member assigned to monitoring the dormitory.

2.4.3 Entry of bedroom corridor by staff

To ensure that staff are not isolated and their personal safety compromised and the safety of tāngata whaiora the following must occur:

- When entering the bedroom corridor there must be at least TWO staff members present at all times
- Staff must carry a duress alarm on their person at all times during their duty.

2.4.4 Access to the bedroom corridor outside of general bedroom access times

Tāngata whaiora wishing to access the bedroom / shower areas outside of general bedroom access times will be locked in the corridor, one tāngata whaiora at a time. There must be a sign placed at the bedroom corridor advising the same. Staff will ensure that they are available to allow tāngata whaiora into the communal area when requested

Tāngata whaiora must be checked as per the individual's level of observation whilst in this area.

2.4.5 Following general bedroom access times

At completion of periods of general bedroom access the observing staff member must make a check of all the bedrooms to ensure rooms have been vacated and bedroom and corridor doors are locked.

3 Patient information

Ward information for tāngata whaiora

4 Audit

4.1 Indicators

- Levels of observations
- Daily duty allocation
- DATIX incident forms

4.2 Tools

- DATIX incident reporting system
- Levels of observation audit
- Auditing of daily duty allocation

5 Evidence base

5.1 Associated Waikato DHB Documents

- Mental Health and Addictions Duress alarm use and management inpatient Mental Health and Addictions procedure (2681)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (5238)

5.2 External Standards

- Health and Disability Services Standards NZS8134:2008 until the 28th February 2022
- Health and Disability Services Standards NZS8134:2021 from 28th February 2022

Clinical Psychology Referrals and Waiting List Procedure

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions Service
Document Facilitator Name	Kirstin Thomson
Document Facilitator Title	Clinical Lead Psychology
Document Owner Name	Dr. Rees Tapsell
Document Owner Title	Clinical Services Director, Mental Health and Addictions
Target Audience	Mental Health and Addictions staff affected by the Clinical Psychology Referrals and Waiting List Procedure outside of the Forensic Service
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
2.0	Gerard Pauley	10/06/2019	Removal of unnecessary sections and updating of language.
2.0	Gerard Pauley	01/07/2019	Further changes to wording on the basis of feedback from draft version sent to staff.
3.0	Kirstin Thomson	01/08/2022	Addition of readiness of therapy Changes made to reflect increased demand on psychology
3.0	Kirstin Thomson	18/10/22	Further changes based on feedback from draft version sent to staff.

Clinical Psychology Referrals and Waiting List Procedure

Contents

Clinical Psychology Referrals and Waiting List Procedure

1. Overview

1.1 Purpose

To detail the process for accessing psychological interventions for a tāngata whaiora and the processes for managing a psychology waiting list.

1.2 Staff group

Staff in the Mental Health and Addictions Services, with the exception of the Puawai service.

1.3 Patient / client group

All tāngata whaiora within Mental Health and Addictions Services, except in the Puawai service.

1.4 Exceptions / contraindications

The Puawai Service.

1.5 Definitions and acronyms

CWS	Clinical Work Station
iPM	Individual Patient Management
MDT	Multidisciplinary Team

2. Clinical management

2.1 Equipment

- iPM psychology waiting list.
- Paper and spreadsheet versions of waiting lists held by each Psychology Clinical Lead or their designate.

2.2 Procedure

Information derived from a clinical assessment and/or a MDT meeting indicates that a psychological intervention could be utilised in the treatment of a tāngata whaiora. Examples of typical psychological interventions include assessments (one-off assessments for specific disorders and neuropsychological assessments) and psychological therapy (either for a specific component of a person's presentation or for extensive psychological input).

The tāngata whaiora has also indicated their willingness to access a psychological intervention.

- ability and willingness to attend weekly/fortnightly appointments
- acknowledgement that psychological interventions would be of benefit
- identification of psychological treatment goals
- if there are missed appointments (DNA's), their MDT will be informed and the suitability for further sessions with the psychologist will be reviewed

This information is summarised into an internal referral form in CWS or, if local protocols still use paper referrals, onto a psychology referral form (Appendix A) and is reviewed by the waitlist manager and /or by the Clinical Psychologists. Based on the referral information and file review, a decision is made about whether a psychological intervention will form part of the tāngata whaiora treatment. If suitability for psychology is unclear, a Clinical Psychologist can complete a psychology review. The outcome of the reviews will be discussed with the MDT and updated on CWS.

If a decision cannot be made then the Psychology Clinical Lead (or their designate), the Team Leader / Charge Nurse Manager, the clinician who made the referral and, if relevant, a Consultant Psychiatrist should meet separately to come to a resolution.

Decision to Provide a Psychological Intervention

If the referral for psychological intervention is accepted, consideration is given to the acuity of the need, the recovery plan goals that relate to the psychological intervention and the current availability of Clinical Psychologists. Typically, when a tāngata whaiora is initially seen by a Clinical Psychologist it is for a psychological assessment prior to starting any intervention to evaluate whether, for a range of different reasons, they are likely to benefit from it at that point in time and shared with the MDT.

As a part of the initial period of contact with the tāngata whaiora, the Clinical Psychologist will collaboratively set goals with them around their intervention and add these to their recovery plan. If appropriate, whānau may be involved in this process. Alternatively, if the outcome of this assessment is that the tāngata whaiora is not going to benefit from a psychological intervention, this finding should be discussed with them, their whanau (if appropriate), and then shared within the MDT for further discussion.

Decision not to Provide a Psychological Intervention

If it is decided that a psychological intervention is not suitable or will not meet the needs of the tāngata whaiora, then the MDT should make a decision around whether the identified clinical need still requires an intervention and, if so, who will provide this intervention. This information should be entered into CWS and shared with the tāngata whaiora.

Waiting List

If there is no current availability of a Clinical Psychologist, then the tāngata whaiora may be placed onto a waiting list. The MDT and tāngata whaiora are notified that this is the case via letter or email (see Appendix C) and the likely timeframe for waiting is included in the recovery plan. While the tāngata whaiora is on the waiting list, and as a part of their ongoing treatment, they should be reviewed by the MDT on a regular basis. If the tāngata whaiora needs or acuity changes, this should be shared with the clinical lead or the psychology waitlist manager. If they are discharged from secondary services, the tāngata whaiora should be advised by their MDT that their referral to psychology will be closed.

When the tāngata whaiora is near the top of the waiting list and is due to be seen for treatment, the MDT is informed, readiness for the psychological intervention is reviewed and relevant information is entered into the Recovery Plan and CWS.

Management of the Waiting List

The Clinical Lead for Psychology in each area of the service (or their designate) will manage the waiting list and the flow of tāngata whaiora onto and off the list. They will ensure that information about the waiting list is regularly shared amongst their colleagues and with their immediate Team Leader / Charge Nurse Manager so that there is a shared understanding of the status of the tāngata whaiora on the waiting list. An excel spreadsheet will be used to organise information about tāngata whaiora and serve as the basis of understanding the status of the waiting list. The Lead Psychologist for Mental Health and Addictions will also receive a regular update of the current state of the waiting list from each area.

When a tāngata whaiora is added to the waiting list, this information will be passed onto an administrator who will enter it into iPM for the respective waiting list. In addition, the tāngata whaiora will be sent a service-specific standard letter (Appendix C provides an adaptable template) which explains that they are on a waiting list, supports they can access while waiting, as well as an estimate of how long they can expect to wait. It is also expected that the keyworker will inform the tāngata whaiora in person that they are on a waiting list and what this means.

Typically, tāngata whaiora will be taken from the waiting list in chronological order. When the tāngata whaiora is entering treatment with a Clinical Psychologist, the administrator is informed so that they can take them off the waiting list on iPM and place them onto the respective clinician's caseload. Clinical Psychologists are expected to manage their caseloads so that they seek new referrals from the waiting list when they have the capacity to do so and to seek the support of their Clinical Lead and/or Team Leader if they are experiencing difficulties in that regard.

Exceptions

An exception to this waitlist process can apply to tāngata whaiora with elevated levels of acuity (high treatment needs) and/or where the MDT has clearly identified and decided that a more immediate psychological intervention will be most likely to provide benefit in terms of improving their mental health outcomes (high treatment gains).

Requests for one-off assessments by Clinical Psychologists can be made and these should also be managed through the MDT process. Where it is agreed that an exception should be made, arrangements will be made so that tāngata whaiora can be seen as soon as practicable by a Clinical Psychologist.

Infant, Child and Adolescent Mental Health (ICAMHS)

In addition to the procedure as it is written, there are three additional points that apply only to their service:

1. Clinical psychologists will meet on at least a monthly basis to discuss and allocate tāngata whaiora from the waiting list.
2. If a tāngata whaiora still requires clinical psychology after being on the waiting list for three months then the Clinical Lead for psychology, the Clinical Director/Operations Manager and the relevant Team Leader / Charge Nurse Manager should be informed.
3. A separate referral form for ICAMHS (See Appendix B).

3. Audit

3.1 Indicators

1. There is a clear link between a tāngata whaiora recovery goals and the psychological intervention being provided.
2. Goals for the psychological intervention are included in the tāngata whaiora recovery plan.
3. Progress towards the successful completion of therapy goals is noted in progress notes and at three-month recovery reviews.
4. The length of time tāngata whaiora are on a waiting list.

3.2 Tools

1. iPM generated waiting lists.
2. Waiting list spreadsheets kept by the local psychology clinical leads or their designates.

4. Appendices

1. Psychology Referral Form.
2. Psychology Referral Form for ICAMHS.
3. Adaptable Template for a Standard Waiting List Letter.

Appendix A – Clinical Psychology Referral Form

CLINICAL PSYCHOLOGY REFERRAL FORM

Name of Tāngata Whaiora: _____

NHI: _____

Current Diagnosis: _____

What type of input is being requested from psychology?

	1. A psychological assessment only.
	2. A neuropsychological assessment only.
	3. Psychological therapy.

What need(s) / goal(s) has been identified with the tāngata whaiora that a Clinical Psychologist could potentially help them to meet?

_____

_____

_____

_____

_____

What is the level of acuity?

	1. Very Urgent – Risk to self or others
	2. Social or occupational functioning severely affected
	3. As soon as possible

Date of Referral: ____/_____/_____

Referrer: _____

Appendix B – Clinical Psychology Referral Form for ICAMHS

REFERRAL TO PSYCHOLOGY
Only to occur after clinical assessment and must be discussed at MDT)

Date:
Tāngata Whaiora Details (Patient Label):
Current Caregiver/s:
Diagnosis and main presenting problem:
Name of person making referral:
Clinicians involved:
Reason for Referral (Why *you think this child or young person requires psychological assistance*?):
Interventions in place whilst on psychology waitlist:
Referrer Checklist – These points need to be discussed with the client and caregiver prior to the referral being given to the psychology team: 1. Psychology input has been discussed with the service user. 2. Is the service user motivated to attend regular therapy sessions at the ICAMHS clinic? (e.g. transport arranged; committed to weekly/fortnightly sessions?) 3. Is the service user aware that after 2 consecutive missed appointments (DNA's), their key worker will be informed and sessions with the psychologist will be reviewed?

Checklist has been discussed and consent obtained from the child or young person and their family for this referral	**Yes**	**No**

- ***Cases will be reviewed on a case-by-case basis; being at the top of the waitlist does not guarantee they will be seen first.***

Appendix C – Adaptable Template for a Standard Waiting List Letter

(Team Address and Telephone Number/s)

Date

Tāngata whaiora name
NHI
Address

Dear _____

You have been referred to our service for a psychological assessment and/or psychological therapy and are currently sitting on the psychology waitlist. You will be contacted once an appointment with a clinical psychologist becomes available. At present, the current waiting time to be seen by a clinical psychologist is approximately (**insert timeframe).**

In the meantime, you might find the below resources helpful:

https://www.justathought.co.nz

https://heretohelpu.nz

https://www.talkingminds.co.nz/helplines

Should your situation change (i.e., become more urgent or you no longer require a psychological support), please contact Mental Health during normal working hours on the telephone numbers listed above. If your situation becomes urgent outside of these hours then please contact the 24-hour Mental Health Line to talk with someone from the Crisis, Assessment and Home Treatment (CAHT) Team on: 0800 50 50 50.

Ngā mihi

(Name – Service)

Prescribing and Monitoring Clozapine Treatment

1. Purpose and scope

This document provides information and resources to assist prescribers and other clinical staff to initiate clozapine treatment and to guide the subsequent monitoring requirements for patients prescribed clozapine.

Contents

2. Indications

Schizophrenia is the only currently registered indication. A closely related psychotic illness, schizoaffective disorder, is also sometimes treated with clozapine, subject to the same restrictions below. It's also suggested for Parkinson's related psychosis

One or both of the following features must also be present:

- Treatment resistance – defined as a lack of satisfactory clinical improvement despite the use of adequate doses of at least two different antipsychotics each prescribed for an adequate duration. Adequate dose and duration are defined as antipsychotic drug trials of at least 6 weeks duration, including clinically judged compliance, with either
  - oral agents, at daily doses equivalent to at least 10mg/day haloperidol or 6mg/day risperidone (as tolerated), and/or
  - depot intramuscular antipsychotic agents, at comparable equivalent doses, of at least five depot intervals to establish a steady state (minimum three months).

OR

- Treatment intolerance – defined as the failure to achieve clinically effective doses of antipsychotic drug treatment due to intolerable adverse reactions. The trials of two different antipsychotics may be of shorter duration than six weeks if the individual could not tolerate either agent due to:
  - i) neuroleptic malignant syndrome (NMS), or
  - ii) severe extrapyramidal side-effects (pseudoparkinsonism, akathisia, dystonia, tardive dyskinesia), or
  - iii) other intolerable adverse effects (e.g. symptomatic hyperprolactinaemia).

3. Consent (see Appendix 1 for consent document)

The following must occur before treatment commences:

- Indications, possible adverse effects, monitoring procedures, and other treatment options should be fully discussed with the patient and family/caregivers (where available, and subject to health information privacy considerations). The discussion should be supplemented by written information.
  (Note: guidance on health information sharing issues and involving family/whanau can be obtained from the Te Whatu Ora Waikato Information Privacy policy or the Privacy page of the intranet).

AND

- Consent should be obtained from the patient by the prescribing clinician wherever possible. The consent process and discussion of the above issues should be clearly documented in the clinical notes and using the consent to treatment form (Appendix 1).

OR

If the patient is judged incapable of giving informed consent:

- Next-of-kin, where available, should be involved in the consent process, AND
- A second opinion must be obtained from a psychiatrist approved by the Review Tribunal for the purposes of section 59 of the Mental Health Act, AND
- If not already in force, an application for compulsory treatment under the Mental Health Act must be made. Alternatively, a personal order providing for clozapine treatment, or the consent of an appointed welfare guardian.

  Note: Clinicians should clearly document this alternative process, reasons for it, and discussion of the above issues in the clinical record.

4. Clozapine Registration (see Appendix: 2A Clozaril® registration form)

- Due to the risk of agranulocytosis, patients must be registered with the clozapine supplier's national blood monitoring programme and database. This is intended to enhance haematological safety and to prevent patients from being re-exposed to clozapine if they had previously developed neutropenia or agranulocytosis.
- To enable this, a patient registration document needs to be completed at the conclusion of the pre-treatment process (detailed below) and sent to the supplier's blood monitoring system, with a copy sent to the pharmacy supplying clozapine.(Appendix 2A)
- When patients are registered in the national database, an acknowledgement is routinely sent to the prescribing clinician and should be recorded in the notes.
- Appendix 2B is for Carelink Plus New User Registration Form for Healthcare Professionals

5. Pre-treatment (see Appendix 3: Clozapine Pre-treatment Checklist)

Following the decision by a psychiatrist (or by a psychiatric registrar in consultation with a supervising psychiatrist) to initiate clozapine, the following must be reviewed or arranged (also see Appendix 3).

- Baseline clinical assessment of function and symptoms, including HoNOS and GAF. Completion of additional rating scales is encouraged, e.g., PANSS, BPRS, GATES, AIMS.
- Medical history review with particular focus on seizures, constipation, cardiovascular disease and any haematological disorder. Family history of cardiovascular disease, especially prior to 50 years of age, is important to ascertain and document.
- Physical examination including abdominal examination, weight, height, pulse and blood pressure (lying and standing), temperature, waist circumference. Body mass index (BMI) should be calculated from measurements of weight and height (kg/m2). Pre-existing constipation should be assessed and adequately treated before clozapine initiation.
- An ECG is required within the four weeks prior to clozapine initiation. Any abnormalities (including QTc prolongation) should be considered in light of current drug treatment, and a risk-benefit analysis undertaken prior to initiation of clozapine. Specialist cardiology opinion may be required.
- Baseline echocardiogram -- if indicated by significant cardiac history (MI, heart failure, valvular disease) or abnormal ECG (other than prolonged QTc due to medication).
- A chest X-ray is required within the 6 months prior to initiation.
- Baseline complete blood count (CBC), electrolytes, renal and liver function tests, troponin-T, C-reactive protein (CRP), fasting blood glucose, HbA1c and lipid profile are also required, sampled no more than 10 days before initiation.
- Patients must be registered with the relevant national blood monitoring system prior to treatment initiation (see Section 4 above).
- General practitioners should be contacted regarding the decision to prescribe clozapine for any of their patients. Discussion should establish who will be responsible for cardiovascular, gastrointestinal, glycaemic and haematological monitoring (usually the psychiatrist); this should be documented in the notes, along with confirmation of who will manage emergent problems in any of these domains (usually the GP).

6. Commencement of treatment (see Appendix 4)

Given the level of care needed in the initial phase of treatment clozapine is recommended be commenced in an inpatient setting. Commencement in prison or in the community setting is not recommended. It will be very unusual for clozapine treatment to be commenced in a private setting.

6.1. Switching from another antipsychotic to clozapine:

Low to moderate potency first generation antipsychotics (such as chlorpromazine) have marked anticholinergic and sedative effects and lowering of the seizure threshold similar to clozapine. Combined treatment may lead to delirium or seizures.

All antipsychotics (including second generation agents) also carry a risk of agranulocytosis and should be used for as short a period as possible during the changeover.

Depot antipsychotics should not be administered after commencement of clozapine, which can occur on the day the depot is due.

6.2. Titration (See Appendix 5):

- Clozapine should be started with a small daily dose (12.5–25 mg) rising in graduated increments over two to three weeks until a good clinical response is seen or a dose of 300 mg/day is obtained.
- Further dose increases may be made according to clinical response. Maori and European patients generally require similar doses, while patients of Asian ethnicity may require slightly lower doses.
- The maximum recommended dose of 600mg/day is rarely needed although doses up to 900mg/day (the maximum licensed dose) can be given in exceptional cases.
- The risk of seizures is dose-dependent and rises substantially in doses over 600 mg/day. Clozapine serum level monitoring may be appropriate if non-compliance or toxicity are suspected, or occasionally if doses above 600 mg/day are prescribed.
- After stabilisation of the patient's clinical state, the dose of clozapine can often be tapered to a lower maintenance dose. Clozapine may be given as a single daily dose (usually in the evening) but divided doses may enhance tolerability, particularly with total daily doses above 200 mg/day.
- Pharmacies will not dispense clozapine unless patients are registered with a national monitoring system (see Section 4, above), AND

- **Only** after complete blood counts are made available and screened by the pharmacy. Any deviations from white blood cell (WBC) and absolute neutrophil count (ANC) normal ranges will be reported to the clinician and treating team.

7. Monitoring

7.1. Blood counts:

Weekly CBCs are mandatory for the first 18 weeks. Thereafter CBCs are required at least monthly (once every 28 days) as long as treatment continues.

An immediate CBC must be performed:

- If signs or symptoms of infection occur. The patient should be regularly reminded to contact the treating doctor immediately if any kind of infection begins to develop. Particular attention should be paid to flu-like complaints such as fever or sore throat, which may indicate neutropenia.

CBC monitoring should be continued at least twice weekly (**Amber** Alert Level):

- If an immediate CBC has been required, until a normal result is obtained.
- If the WBC shows a drop of 3.0 x10^9/L or more from baseline or a single drop of 3.0x10^9/L or more.
- If the ANC falls to (1.5-2.0)x10^9/L, or there is a single drop of 3.0x10^9/L or more.

Immediate discontinuation of clozapine (Red Alert Level) is required if:

- The WBC is less than 3.0x10^9/L or the ANC count is less than 1.5x10^9/L.
  - Obtain daily blood tests to confirm and track the need to resume clozapine, and get a haematology consult with the full blood count history available to discuss.
  - Daily CBCs should be performed until haematological recovery has occurred and the patient must be closely monitored, especially for any signs of infection.
  - If WBC or ANC drop persists consult with a Haematologist regarding the use of filgrastim (GCSF).

General Cases:

	WBCx10^9/L	ANCx10^9L
Amber	3.00-3.50	1.50-2.00
Red	<3.00	<1.50

Special cases of patients with persistently low WBC and/or low ANC counts:

Some patients show persistently low WBC and/or low ANC counts without any significant adverse effects, such as in patients with benign ethnic neutropenia, or chronic idiopathic neutropenia. In patients - with conditions such as these - who have no significant adverse effects, the Waikato Hospital haematology department have recommended the following cut off levels:

	WBCx10^9/L	ANCx10^9L
Amber	2.00-3.50 (with approval*)	1.00-1.25 (with approval*)
Red	<2.00 (with approval*)	<1.00 (with approval*)

*Please refer to Haematologist for approval to continue with the revised cut-off levels. Mental Health Pharmacist to be notified.

Immediate discontinuation of clozapine (for other blood components) if:

- The eosinophil count rises above 3.0x10^9/L. Clozapine should only be restarted after the count is below 1.0x10^9/L.
- The platelet count falls below 50x10^9/L. Clozapine should not normally be reinitiated. However, if consideration is being given to reinitiate clozapine the patient's platelet count must be greater than 100x10^9/L, and a haematologist must be consulted. If a patient refuses a blood test at any stage and cannot be persuaded to reconsider, then clozapine must be discontinued and the patient's physical condition monitored for at least one month following discontinuation. Ideally the CBC should also continue to be monitored for a period of one month following discontinuation.

Covid 19 and haematological changes: Data are emerging that show a reduction in WCC, neutrophils and lymphocytes in patients taking clozapine who become infected with COVID-19. This reduction is small (mean of around $1x10^9$/L) and transient, recovering within 2 weeks.

- For some patients this temporary reduction in WCC and neutrophils may be sufficient to cause their blood tests to be classified as 'amber' or even 'red'. If clozapine-related neutropenia can be ruled out, it is not always necessary to stop clozapine for these patients. Stopping clozapine is very likely to cause a relapse in symptoms. Clozapine-related neutropenia can usually be ruled out if the neutropenia occurs in patients taking clozapine for more than six months, especially if more than a year. In addition, true clozapine related neutropenia follows a characteristic pattern of a precipitous fall in neutrophil counts of 'normal to nil' over a week or less.
- On the basis of our findings, clinicians should act to rule-out COVID-19 in patients presenting with a fall in neutrophil counts.

7.2. Monitoring for myocarditis and cardiomyopathy:

- Routinely add markers of inflammation (CRP or ESR) and cardiac muscle damage (troponin or CK) to the already mandated weekly routine bloods for first 4 weeks. CRP and troponin together are perhaps the best combination with regard to sensitivity and specificity.
- Routinely monitor vital signs including temperature on the day of blood tests, particularly for the first 4 weeks
- Obtain ECG and cardiac enzymes as soon as clinical concerns for myocarditis arise. If a recent, pre-symptomatic baseline ECG is on file, ECG changes can be better interpreted.
- Clozapine patients who develop fever, tachycardia (new onset or worsening), shortness of breath (at rest or on exertion), chest pain, palpitations, unexplained fatigue, ECG changes, arrhythmias or any other symptoms of heart failure should be investigated promptly. This includes a medical assessment, CBC, and consider testing for cardiac biomarkers (including BNP, troponin-T and CRP).
- Pay attention to any rise in eosinophil count after the high-risk period which may indicate subclinical myocarditis.
- Echocardiography should be performed, in consultation with a cardiologist, if elevations of cardiac inflammatory markers are detected.
- Rapid or severe deterioration warrants immediate hospitalisation for assessment.
- If myocarditis or cardiomyopathy is suspected, referral to cardiac specialists must be undertaken immediately. Ongoing administration of clozapine should be discussed with the cardiology team.
- In all cases referral should include an ECG, chest X-ray and an echocardiogram request. The referral must clearly identify that the person is being treated with clozapine.

Covid-19 vaccination and myocarditis and pericarditis

- A small increased risk of pericarditis and/or myocarditis has been observed in people who have received an mRNA COVID-19 vaccine (including Comirnaty (Pfizer) and Spikevax (Moderna), compared to unvaccinated people.
- COVID-19 itself is associated with a substantially higher risk of myocarditis and other cardiac complications compared with vaccination.
- Pericarditis and myocarditis after mRNA COVID-19 vaccines have been reported most commonly in males under 30 years of age, and most commonly after the second vaccine dose. Most myocarditis and pericarditis linked to mRNA vaccination has been mild and patients have recovered quickly. Longer-term follow-up is ongoing.
- Symptoms of myocarditis or pericarditis typically appear within 1-5 days of an mRNA vaccine dose and may include chest pain, palpitations (irregular heartbeat), syncope (fainting) or shortness of breath. People who experience any of these symptoms after having an mRNA COVID-19 vaccine should seek prompt medical attention.
- Initial investigations should include ECG and blood troponin levels. A chest X-ray, and other investigations for other differential diagnoses should be undertaken as clinically indicated.
- Future vaccine dose recommendations vary depending on investigation results.

7.3. Serum levels:

Patients show considerable variability in clozapine serum concentrations due to dose and to biological differences in absorption and metabolism. Studies indicate an inconsistent relationship between serum levels and clinical response. Clozapine serum levels should thus be performed only for a specific purpose and should NOT be performed routinely. The situations in which it may be useful to consider clozapine serum level testing include:

- Poor clinical response despite adequate dosage.
- Signs of toxicity at therapeutic doses, e.g. excessive sedation, hypersalivation or constipation, seizures.

- Concomitant medications or substances that may affect the metabolism and serum level of clozapine, e.g. change in tobacco smoking or caffeine consumption.
  - By-products of tobacco smoking, particularly polycyclic aromatic hydrocarbons, are metabolic inducers of cytochrome P450 1A2, which increases clozapine metabolism thereby lowering clozapine serum levels. This requires an increased dose of clozapine for the same therapeutic effect.
  - Likewise when a patient reduces or quits smoking, clozapine levels typically rise due to normalisation of CYP 1A2, and clozapine dose will need to be reduced. This scenario warrants review and sometimes monitoring of clozapine serum level.
  - Caffeine is a competitive substrate for CYP1A2 thus displacing clozapine and raising levels. This is one reason why decaffeinated coffee has become the norm in the inpatient setting. Discharged patients who resume regular coffee consumption likewise warrant review and may require clozapine level monitoring.
- Co-morbid medical disorders, especially with hepatic impairment.
- There has been case reports of Covid-19 Infection affecting clozapine serum levels. Case studies indicate that coronavirus disease 2019 (COVID-19) can be associated with toxic clozapine levels, requiring monitoring to maintain therapeutic levels and prevent relapses of psychosis.1–4 High clozapine levels are consistent with infection-related inflammation inhibiting cytochrome P450 1A2 (CYP1A2) and slowing clozapine metabolism.5
- Suspected non-adherence.
  Serum clozapine levels over 2000 nmol/L appear associated with an increased risk of neurological effects. In such circumstances, the clozapine dose may be adjusted to maintain a serum level within the usual therapeutic range (1050 – 1800 nmol/L) if the patient's clinical condition permits. Sampling is best done between 10-16 hours following last dose, ideally 12 hours.

7.4. Assessment of adherence:

It may be worth taking serum levels on different days to the CBC; this may be more likely to detect non-adherence if the patient only adheres when they know a blood test is due.

Total non-adherence is easy to diagnose as both clozapine and N-desmethylclozapine levels will be low or non-existent. Conversely, serum clozapine and N-desmethylclozapine levels within the expected ranges do not guarantee adherence for more than a week or so.

Partial adherence is difficult to detect. If the clozapine level is congruent with previous results but the N-desmethylclozapine level is relatively low, this may indicate recent adherence but longer term partial or non-adherence.

7.5. Other parameters of monitoring:

Appropriate interventions should be made if any of the following are found to be abnormal:

- **Daily recordings of pulse and blood pressure** (both lying and standing), temperature and bowel movements are recommended during the dose titration period. Thereafter these observations should be recorded as required due to adverse effects or a change of dose.
- **Weight, height, waist and hip circumference** should be measured, and Body Mass Index (BMI) and waist/hip ratio calculated at baseline and monitored regularly.
- **Fasting blood glucose levels** and HbA1c are recommended at baseline and three months after starting treatment, then at six months and annually thereafter (or more frequently if clinically indicated). For people at high risk of developing diabetes monitor monthly for three months, then every three months for the first year, then every six months thereafter.
- **A fasting lipid screen** is recommended at baseline and then three months, then at six months and then annually (or more frequently if clinically indicated). For people at high risk monitor monthly for three months, then every three months for the first year, then every six months thereafter
- **Liver function tests** are recommended to be assessed at baseline, three months and six months after starting treatment and then annually (or more frequently if clinically indicated).
- **An ECG** should be monitored annually. Anyone with ECG changes should be investigated.
- **Myocarditis /cardiomyopathy** occurs rarely in the first few months of treatment and very rarely later in treatment. Myocarditis has a very rapid onset and there are no screening tests of proven value, indeed these can lead to a false sense of reassurance. Effective monitoring for these serious complications is heavily reliant on careful clinical vigilance.
  - There are few reports of Covid 19 associated myocarditis - occur predominantly in adolescents and young adults, more often in males than females, more often after the second dose of the vaccine, and typically within 4 days after vaccination [1]. Most cases appeared to be mild and follow up is ongoing.
  - Anyone who develops fever, tachycardia (new onset or worsening), shortness of breath (at rest or on exertion), chest pain, palpitations, unexplained fatigue, ECG changes, arrhythmias or any other symptoms of heart failure should be

investigated promptly. This includes a medical assessment, FBC, and consider testing cardiac biomarkers (including BNP, troponin-T and CRP).
- Baseline echocardiogram -- if indicated by significant cardiac history (MI, heart failure, valvular disease) or abnormal ECG (other than prolonged QTc attributed to medication).
- Rapid or severe deterioration warrants immediate hospitalisation for assessment.
- If myocarditis or cardiomyopathy is suspected referral to cardiac specialists must be undertaken immediately. Ongoing use of clozapine should be discussed with the cardiology team.
- In all cases referral should include an ECG, chest X-ray and an echocardiogram request. The referral must clearly identify that the person is being treated with clozapine.

7.6. Bowel monitoring:

Constipation is a common problem in people taking clozapine. Clozapine can cause gastrointestinal hypomotility throughout the entire digestive system from oesophagus to rectum; the resulting effects can include dysphagia, delayed gastric emptying, bowel obstruction, ischaemia, megacolon and perforation leading to peritonitis. The mechanism is likely due to clozapine's potent antimuscarinic and antiserotonergic activity which inhibit intestinal smooth muscle contraction, resulting in delayed transit, reduced gastrocolic reflexes, and reduced intestinal sensitivity to distension. This is a particular concern when other constipating medications with anticholinergic activity (benztropine, procyclidine, tricyclic antidepressants) or opiates are co-prescribed.

Life-threatening bowel complications have been associated with clozapine use. People may present acutely unwell with an ischaemic, distended bowel. The bowel is normally close to perforation or this has already occurred. Systemic signs of peritonitis or sepsis may be present. Whilst perforation is uncommon, mortality rates are high and more deaths have occurred in New Zealand from this complication than from agranulocytosis. Risk factors include higher doses of clozapine (and subsequently higher plasma levels): co-morbid medical illness and fever (inhibiting clozapine metabolism and increasing plasma levels); co-administration of medications that inhibit CYP1A2, increasing clozapine plasma levels; and the first four months of treatment may be a particularly vulnerable time with 36% of cases occurring then. The most consistently reported presenting signs and symptoms are moderate/severe abdominal pain, abdominal distension, and vomiting. If a person presents with these symptoms urgent surgical (or medical) referral and treatment is required. Clozapine treatment should be reduced or withheld.

Constipation should be assessed on an ongoing basis and treated to ensure it has resolved adequately. Bowel movement monitoring is essential in the early phase of treatment.

The Porirua Protocol (Appendix 6)

- The Porirua protocol is a regimen of laxatives for the prevention and treatment of clozapine-related constipation that was first published in 2014 by researchers at the University of Otago, Wellington. The protocol primarily uses docusate sodium with sennoside B, with an additional laxative for patients with resistant constipation. A small study of 14 patients taking clozapine found that the Porirua protocol reduced the average time for material to pass along the colon by two days. *
  - When clozapine is initiated, patients should be concurrently prescribed two tablets of docusate sodium with sennoside B each night to prevent the onset of constipation.
  - If the patient has not had a bowel movement for two days, increase the dose of docusate sodium with sennoside B by one tablet in the morning and review the patient within 48 hours.
  - If still constipated, increase the dose again by one tablet in the morning and review the patient within 48 hours.
  - If the patient remains constipated, a rectal examination should be performed to exclude impaction:
    - If impacted, docusate sodium with sennoside B should be stopped and the patient discussed with a psychiatrist or gastroenterologist; manual dis-impaction and enemata may be required
    - If not impacted, continue with two tablets of docusate sodium with sennoside B, twice daily, and review after 48 hours.
  - If constipation persists, add one macrogol sachet, twice daily, and review after 48 hours.
  - If constipation is ongoing the patient should be discussed with a gastroenterologist.
    * If the patient develops diarrhoea it may be appropriate to reduce the dose or withdraw laxative treatment; close monitoring is essential.
  - Red flags for constipation in clozapine patients requiring urgent medical review:
    Moderate to severe abdominal pain which lasts for more than one hour
    Any abdominal pain or discomfort which lasts for more than one hour and one or more of:
    - Abdominal distension
    - Diarrhoea, especially if bloody
    - Vomiting

- Absent or high-pitched bowel sounds
- Haemodynamic instability
- An elevated white blood cell count
- Metabolic acidosis
- Additional signs of sepsis

7.7. Interruptions in clozapine treatment: Dosage and blood monitoring requirements:

Period of interruption	Dosage & blood monitoring requirements
2 days or less (48 hours)	No change to dosage or blood monitoring requirements.
3 days (72 hours)	Start on 12.5mg and titrate up. Maintain current blood monitoring.
>3 days but <4 weeks	Start on 12.5mg and titrate up. For patients on monthly CBC monitoring: Weekly monitoring for 6 weeks. If no abnormality, resume monthly blood monitoring. For patients on weekly CBC monitoring: continue weekly blood monitoring for 6 weeks or as long as needed to reach 18 weeks. Notify clozapine clinical support technician (0800 535 020 or carelinkplus@viatris.com) to ensure national database system is updated.
> 4 weeks	New Patient registration form required A new pre-treatment blood result and blood monitoring as for new patients (weekly for 18 weeks). Start on 12.5mg/day and titrate up.

8. Withdrawal of treatment

8.1. Discontinuing treatment (Appendix 7 Discontinuation Notice):

If clozapine treatment is to be discontinued, where possible the dose should be gradually reduced to avoid rebound exacerbation of psychotic symptoms or cholinergic rebound.

If abrupt discontinuation is necessary, the person should be closely monitored for a period of two to three weeks for rebound psychosis. An anticholinergic medication may be required to manage cholinergic symptoms on withdrawal.

As noted above, the CBC should be monitored for a period of one month following cessation of clozapine treatment (at weekly intervals if the patient is on weekly monitoring, or one further CBC at one month if the patient is on monthly monitoring).

8.2. Reasons for stopping clozapine:

1. Haematological factors (drop in WBC or ANC as per guideline)
2. Other severe adverse effects (e.g. suspicion of cardiotoxicity, uncontrolled seizures, neuroleptic malignant syndrome, severe sedation, intolerable hypersalivation, severe constipation).
3. No improvement (reflected in HoNOS or GAF) with adequate clozapine serum level (above 1000nmol/L) over a minimum period of six months. Augmentation strategies may be considered.
4. Withdrawal of consent if not under the Mental Health Act.
5. Persisting non-compliance with treatment or monitoring despite reasonable attempts to ensure this.

Should treatment be withdrawn for any reason, the relevant pharmaceutical company (for Te Whatu Ora Waikato, Mylan) must be informed of the date and reason for discontinuation so that the monitoring database can be updated.

8.3. Re-challenge:

- For those whose clozapine is discontinued because of agranulocytosis, clozapine must not be reinitiated at any time.
- For those whose clozapine is discontinued because of neutropaenia, clozapine must only be reinitiated after consultation with a haematologist and the relevant national monitoring system.
- Clozapine re-challenge may be considered for some patients who have experienced previous severe adverse effects (e.g. haematological or cardiotoxicity).
- This should be carefully discussed with appropriate specialists and the risks, benefits and alternatives documented and discussed with the patient, family/whanau and other caregivers as appropriate.
- To be considered after full clinical resolution of the toxicity and, in the case of cardiac adverse effects, lack of evidence of residual functional impairment.
- Under closely controlled conditions, initially typically in hospital and restarting with low, slowly increased doses.
- Frequently repeated assays of laboratory and cardiac markers that had been abnormal during acute myocarditis is mandatory; these patients typically require close inpatient monitoring.

9. Transfer of care of clozapine patient (appendices 8 and 9)

Complete and send the documents in appendices 8 and 9 when a patient prescribed clozapine is transferring into the community or to another hospital/care facility

10. Definitions

AIMS	Abnormal Involuntary Movement Scale
ANC	Absolute Neutrophil Count
BPRS	Brief Psychiatric Rating Scale
CRP	C-Reactive Protein
CK	Creatine Kinase
ESR	Erythrocyte Sedimentation Rate
CBC	Complete Blood Count
GAF	Global Assessment of Function
GATES	General Akathisia Tardive phenomena & Extrapyramidal rating Schedule
HoNOS	Health of the Nation Outcome Scale
PANSS	Positive and Negative Syndrome Scale
WBC	White Blood Cell

11. Associated documents

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Protection of Personal and Property Rights Act 1988.
- Clozaril®, Viatris Ltd. Medsafe data sheet 13 March 2023
- Clopine®, Douglas Pharmaceuticals Ltd. Medsafe data sheet 29 July 2021.
- ClopineConnect® Resource Folder
- Clozaril® Resource Folder 2010

Prescribing and Monitoring Clozapine Treatment

12. References

1. Waitemata Best Practice Guideline for clozapine 014-001-01-091 July 2011
2. MHS Forensic Clozapine Resource Folder 2010
3. Capital & Coast DHB Clozapine Initiation and Monitoring Pack MHS July 2018
4. Menkes DB, et al. (2017). Steady-State Clozapine and Norclozapine Pharmacokinetics in Maori and European Patients. EBioMedicine. doi:10.1016/j.ebiom.2017.11.030
5. Guna Kanniah*, Shailesh Kumar. Clozapine associated cardiotoxicity: Issues, challenges and way forward Asian Journal of Psychiatry 50 (2020) 101950
6. Siobhan Gee, Fiona Gaughran, James MacCabe, Sukhi Shergill, Eromona Whiskey and David Taylor . Management of clozapine treatment during the COVID-19 pandemic Ther Adv Psychopharmacol 2020, Vol. 10: 1–10
7. Guidance on Myocarditis and Pericarditis after mRNA COVID-19 Vaccines by Australian Technical Advisory Group on Immunisation (ATAGI), the Cardiac Society of Australia and New Zealand (CSANZ), the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), the Australasian College for Emergency Medicine (ACEM) and the Paediatric Research in Emergency Departments International Collaborative (PREDICT).Updated 8 November 2021
8. Consensus statement on the use of clozapine during the COVID-19 pandemic
   Dan Siskind, William G. Honer, Scott Clark, Christoph U. Correll, Alkomiet Hasan, Oliver Howes, John M. Kane, Deanna L. Kelly, Robert Laitman, Jimmy Lee, James H. MacCabe, Nick Myles, Jimmi Nielsen, Peter F. Schulte, David Taylor, Helene Verdoux, Amanda Wheeler and Oliver Freudenreich
   J Psychiatry Neurosci May 01, 2020 45 (3) 222-223; DOI: https://doi.org/10.1503/jpn.200061
9. Guidance on Myocarditis and Pericarditis after mRNA COVID-19 Vaccines. Updated 8 November 2021. health.gov.au/covid19-vaccines
10. MEDSAFE Safety Information Alert Communication-Important updates to clozapine data sheets and monitoring during covid-19 pandemic. Published: 9 June 2020 Revised: 6 November 2020

Document Ownership

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Appendix 1 – Consent for Treatment with Clozapine

CONSENT FOR TREATMENT WITH CLOZAPINE

Clozapine (trade name "Clozaril") is an antipsychotic medicine used to treat disturbances of thinking which occur in schizophrenia and related psychoses.

Advantages of clozapine:

1. Clozapine is an effective medicine for schizophrenia. It may help some people who have not been helped by other antipsychotic medicines. It may also help treat some symptoms that are not helped by other medicines.
2. Clozapine is much less likely than other similar medicines to cause side effects such as stiffness, unusual movements or restlessness. In particular, clozapine is not known to cause tardive dyskinesia. This is a condition which involves unwanted movements of the tongue, mouth, face or limbs. It may occur with long-term use of some other medicines used in schizophrenia.

Disadvantages of clozapine:

1. Clozapine can cause serious side effects in a few people. These include:
   - A decrease in the number of white blood cells which fight infection.

   This can lead to serious or even fatal infections if it is severe and not treated quickly. To decrease the risk of this reaction being severe, it is necessary to have frequent blood tests while taking clozapine. This will mean having a blood test at least once a week for the first 18 weeks of treatment, then at least every four weeks thereafter. Extra blood tests may be required at any sign of infection i.e. sore throat or fever.
   - Constipation is common and can be serious. If it occurs, report this to your nurse or doctor
   - Possible increased risk of diabetes or metabolic syndrome
   - Seizures or fits. These are more likely to occur when taking higher doses of clozapine. If it occurs, report this to your nurse or doctor
   - Myocarditis (inflammation of heart muscle) or cardiomyopathy are rare adverse effects
2. Other side effects are less serious but may be unpleasant for some people. The more common ones include drowsiness, fast heart rate, weight gain, increased saliva, and dizziness.

In order to lessen the risk of a serious reaction to clozapine, blood test results are checked by the pharmacist before they can dispense clozapine. These results are also shared with the pharmaceutical company that supplies clozapine – Mylan - together with your name, sex, age, doctor's name, pharmacy name. All agencies are bound to keep this information confidential.

Statement of Service User/Tangata Whaiora

I have had the benefits and drawbacks explained to me concerning clozapine treatment. I understand the above information and realize that clozapine may help me but may also lead to serious side effects. I agree that while I am taking this medicine I will have blood tests when asked by my doctor or other staff.

Service user /Tangata Whaiora name..... Date of birth.....

Signature ..... Date .....

Next Of Kin

Have next of kin been informed or been part of the treatment discussions? Yes☐ No ☐

If yes, who?: .....

If no, what were the reasons? .....

.....

Statement of Witness

I have discussed this consent form with this service user/Tangata Whaiora and next of kin (if applicable) and am satisfied that they fully understand it and their consent is freely given.

Name: ..... Position:.....

Signature: ..... Date.....

Appendix 2A – Patient Registration Form

CONFIDENTIAL

Patient Registration

Please return to Viatris Limited PRIOR to commencing *Clozaril* treatment

▶ By Email: **carelinkplus@viatris.com**

Patient Family Name .....

First Name(s) .....

Date of Birth ... / ... / ... NHI Number ..... Sex ☐ M ☐ F

Dispensing Pharmacy .....

Laboratory .....

Consultant ..... Email .....

Mental Health Unit/Team .....

Phone Number .....

Pre-treatment baseline WBC and Neutrophils

Date: ... / ... / ...

White Blood Count ..... $x10^9$/L Neutrophils (absolute) ..... $x10^9$/L

Treatment start date: ... / ... / ...

The pretreatment baseline WBC and Neutrophil counts must be from a blood sample taken no more than 10 days before starting *Clozaril* treatment. These should be in the normal range.

Statement

"I am a medical practitioner registered by the Medical Council of New Zealand in the scope of practice of psychiatry. I confirm that I have explained to the patient the purpose of the Viatris CareLink Plus Database ('Database') and that:

(a) patient name, gender, Date of Birth, NHI number, *Clozaril* treatment dates and dose(s) will be stored in the Database

(b) following every blood test the patient's white blood count and neutrophils will be provided to Viatris Limited, New Zealand by the testing laboratory and stored in the Database

(c) health professionals and dispensing pharmacies will have access to such information

(d) the patient will be entitled to access such information

I also confirm on behalf of the patient that the collection, storage, use and disclosure of such information has been authorised by, or on behalf of, the patient."

Print Name: ..... Signature: .....

Date: ... / ... / ... Consultant ☐ Registrar (on behalf of consultant) ☐

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CareLink PLUS Clozaril® (clozapine)

Appendix 2A – Patient Registration Form (continued)

Privacy Statement: Viatris Limited ('Viatris New Zealand') collects and holds, uses, and discloses personal information, such as name and contact details of patients and healthcare professionals ('HCPs') and the health information of patients, for the purpose of operating and administering the *Clozaril* patient blood monitoring program ('Program') for participating patients on the Carelink Plus database ('Database'). This includes registering HCPs and patients on the Database, storing patients' blood tests, monitoring patients' use of the products, communicating with HCPs and patients about the products to support the administration and use of the products, complying with regulatory obligations (including the reporting and processing of adverse events patients may experience), and sending invitations to participate or arranging for participation in activities managed by or on behalf of Viatris New Zealand. Viatris New Zealand may need to disclose this personal information to its third party services providers and affiliates, who may be located overseas, for these purposes, and personal information in the Database is held on Viatris New Zealand's behalf in servers located overseas in the UK and/or Ireland. By providing your personal information to Viatris New Zealand, you agree that you understand this Privacy Statement. If you are an HCP, you consent to Viatris communicating with you to facilitate the transmittal of invitations to participate or arranging to participate in activities managed by or on behalf of Viatris New Zealand. Viatris is committed to patient safety. In accordance with regulatory obligations, Viatris has a systematic process in place to collect, store, and process reports of adverse events experienced by patients taking a Viatris product, when identified by a Viatris representative (or by a third party acting on behalf of Viatris). All information forwarded to the Viatris drug safety department is treated in accordance with local privacy laws and may be captured and processed in countries outside of the jurisdiction in which it was collected, and shared with health authorities or other pharmaceutical companies with whom Viatris has a license agreement for the purpose of meeting the regulatory requirements for reporting safety information on Viatris products. Viatris drug safety department may contact the patient's HCP to collect further information on the adverse event. You are not obliged to provide personal information. However, if you do not provide information you may not, for example, be able to participate fully in activities managed by us. You have the right to access, update or correct your personal information and/or decline to receive communications from Viatris. To find out how, please refer to our: Privacy Policy https://www.viatris.com/en-nz/lm/new-zealand/viatris-privacy-notice or contact Viatris New Zealand, PO Box R1462, Royal Exchange Post Office, NSW, Australia 1225. Email: dataprivacy_JANZ@viatris.com

***Clozaril* (clozapine) 25 milligrams, 100 milligrams tablets.** Prescription Medicine. Indicated for treatment-resistant schizophrenia in adult patients. Review the datasheet (available from www.medsafe.govt.nz) for information on dosage, contraindications, precautions, interactions, and adverse effects. Prescriber restrictions apply. Persons prescribing clozapine must comply with appropriate local treatment guidelines. *Clozaril* is a Viatris company trademark. Viatris Limited, Auckland. Ph 0800 579 811. CLZ-2022-0110. TAPS DA2211RY-0703. Last updated August 2022.

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Appendix 2B – Carelink Plus New User Registration Form for Healthcare Professionals

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CareLink Plus New User Registration

It is mandatory to complete all sections of this form. This document is a statement of intent from a Healthcare Professional, Mental Health Centre or Pharmacy to participate in the blood monitoring programme for *Clozaril* Patients in association with CareLink Plus - *CLOZARIL* PATIENT MONITORING SYSTEM (CPMS).
Email: carelinkplus@viatris.com

Title: _____

Given Name: _____ Surname: _____

Designation: _____

Mental Health Unit/Pharmacy: _____

Address: _____

Post Code: _____ DHB: _____

Phone: _____ Email: _____

I understand and agree to the conditions of the blood monitoring programme for *Clozaril* Patients as outlined in the *Clozaril* Data Sheet, which I have read. I also agree to have my contact details made available to other Health Care Professionals for the purposes of assisting patients with their blood monitoring.

Signature: _____ Date: ___/___/___

Approved by MHU/Pharmacy Manager/Clinical Director: Name: _____

Signature: _____ Date: ___/___/___

By completing and submitting this registration form by email, you will be registered to access CareLink Plus. The CareLink Plus technician will contact you shortly with your login details.

NB. This information is treated confidentially and used only to update CareLink Plus.

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CareLink PLUS | Clozaril (clozapine)

Appendix 2B – Carelink Plus New User Registration Form for Healthcare Professionals (continued)

Privacy Statement: Viatris Limited ('Viatris New Zealand') collects and holds, uses, and discloses personal information, such as name and contact details of patients and healthcare professionals ('HCPs') and the health information of patients, for the purpose of operating and administering the *Clozaril* patient blood monitoring program ('Program') for participating patients on the Carelink Plus database ('Database'). This includes registering HCPs and patients on the Database, storing patients' blood tests, monitoring patients' use of the products, communicating with HCPs and patients about the products to support the administration and use of the products, complying with regulatory obligations (including the reporting and processing of adverse events patients may experience), and sending invitations to participate or arranging for participation in activities managed by or on behalf of Viatris New Zealand. Viatris New Zealand may need to disclose this personal information to its third party services providers and affiliates, who may be located overseas, for these purposes, and personal information in the Database is held on Viatris New Zealand's behalf in servers located overseas in the UK and/or Ireland. By providing your personal information to Viatris New Zealand, you agree that you understand this Privacy Statement. If you are an HCP, you consent to Viatris communicating with you to facilitate the transmittal of invitations to participate or arranging to participate in activities managed by or on behalf of Viatris New Zealand. Viatris is committed to patient safety. In accordance with regulatory obligations, Viatris has a systematic process in place to collect, store, and process reports of adverse events experienced by patients taking a Viatris product, when identified by a Viatris representative (or by a third party acting on behalf of Viatris). All information forwarded to the Viatris drug safety department is treated in accordance with local privacy laws and may be captured and processed in countries outside of the jurisdiction in which it was collected, and shared with health authorities or other pharmaceutical companies with whom Viatris has a license agreement for the purpose of meeting the regulatory requirements for reporting safety information on Viatris products. Viatris drug safety department may contact the patient's HCP to collect further information on the adverse event. You are not obliged to provide personal information. However, if you do not provide information you may not, for example, be able to participate fully in activities managed by us. You have the right to access, update or correct your personal information and/or decline to receive communications from Viatris. To find out how, please refer to our: Privacy Policy https://www.viatris.com/en-nz/lm/new-zealand/viatris-privacy-notice or contact Viatris New Zealand, PO Box R1462, Royal Exchange Post Office, NSW, Australia 1225. Email: dataprivacy_JANZ@viatris.com

***Clozaril* (clozapine) 25 milligrams, 100 milligrams tablets.** Prescription Medicine. Indicated for treatment-resistant schizophrenia in adult patients. Review the datasheet (available from www.medsafe.govt.nz) for information on dosage, contraindications, precautions, interactions, and adverse effects. Prescriber restrictions apply. Persons prescribing clozapine must comply with appropriate local treatment guidelines. *Clozaril* is a Viatris company trademark. Viatris Limited, Auckland. Ph 0800 579 811. CLZ-2022-0110. TAPS DA2211RY-0703. Last updated August 2022.

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Appendix 3 – Pre-treatment Checklist

A - Clozapine therapy pre initiation checklist

	Process	Dr/RN sign	Date
A1	The patient has been adequately informed about the rationale to initiate clozapine treatment	Dr	
A2	The clinical benefits and potential risks involved have been clearly highlighted	Dr	
A3	The patient and caregiver have been well informed of the two prerequisites: a) compliance with clozapine treatment b) adherence to blood monitoring programme as two conditions upon which the decision to prescribe clozapine rests.	Dr	
A4	Is the patient on medications that risk suppression of bone marrow eg carbamazepine, sulphonamides, trimethoprim? Clozapine should not be prescribed with these medicines.	Yes/No (circle) Dr	
A5	The patient has signed the consent form	Dr	
A5	The following measurements have been completed and documented • Weight and BMI • Baseline complete blood count (CBC), (cannot be earlier than 7 days prior to initiation of clozapine treatment) **Please use Mylan blood request forms so that results will be sent to CarelinkPlus Database and relevant Pharmacy)** • Liver function test (LFT) • Urea and electrolytes (U&Es) • Fasting blood glucose • HbA1c • Fasting lipid profile • B-type natriuretic peptide (BNP) • C-reactive protein • Troponin T • Blood pressure (lying and standing), temperature and pulse rate • Baseline ECG • Baseline chest X ray (within 6 months prior to initiation) • Baseline echocardiogram - if indicated by significant cardiac history (MI, heart failure, valvular disease) or abnormal ECG (other than prolonged QTc)		
A6	The clozapine patient registration form has been completed and forwarded to Mylan CarelinkPlus for registration prior to initiation of treatment. A copy to be faxed to the Pharmacy supplying the clozapine.(The registration form is available in the guidelines and the clozapine resource folder)		
A7	A copy of the registration form has been included in the patient's Clozapine folder		

Appendix 4 – Commencement and maintenance of clozapine treatment

Clozapine initiation and maintenance treatment checklist

	Checklist	Sign	Date
B1	Where complete withdrawal of existing conventional antipsychotic treatment is not practicable, a cross-tapering regimen is in place with the current antipsychotic while clozapine is slowly built up to an adequate dose.	Dr	
B2	The dose titration is appropriate and according to guidelines and the titration chart.	Dr	
B3	The rate of dose increase is guided by the level of patient tolerance and the co-existence of any other physical conditions.	Dr	
B4	The patient's relevant physical symptoms will be closely monitored e.g. flu-like symptoms, sore throat etc	RN	
B5	Close monitoring and/or observation for adverse reactions, particularly risk of seizures, are in place.	RN	
B6	Weekly CBC (white blood count and differential) is being performed for the first 18 weeks of treatment. **Week 1 ____/____/____ Week 18 ____/____/____**	Dr to order. RN	
B7	Liver function tests (LFTs) checked one month following initiation of treatment, then at 3 months and 6 monthly thereafter unless there are clinical indications for more frequent liver function testing. **Week 4 __/___/__** **3 months __/____/___** **6 months ___/___/___**	Dr to order. RN	
B8	Temperature, blood pressure and pulse is being measured and recorded at least once daily during the **first two weeks of treatment**. (Monitoring of physical signs might need to be performed more frequently or for longer than two weeks if any abnormalities are detected during the treatment process.)	RN	
B9	ECG monitored when indicated and if so when was it performed. ____/____/____	Dr to order.	
B10	Blood glucose levels and HbA1c performed at 3 months, then at 6 months or more frequently if clinically indicated (fasting preferable). **3 months ____/____/____ 6 months ____/____/____**	Dr to order. RN	
B11	The frequency of CBC monitoring has been reduced to 4 weekly intervals (provided that no abnormalities were detected after the initial 18 week period.) 4 weekly start date ____/____/____ Four weekly monitoring must remain in place as long as clozapine treatment continues. More frequent monitoring however is required, e.g. weekly or fortnightly whenever blood tests indicate abnormal results.	Dr to order RN	

Appendix 5 - Clozapine titration regime

The Medsafe datasheet recommends an initial starting dose of 12.5 mg with gradual increments to achieve a total daily dose of 300mg in 14-21 days. One example of dose titration is illustrated below.

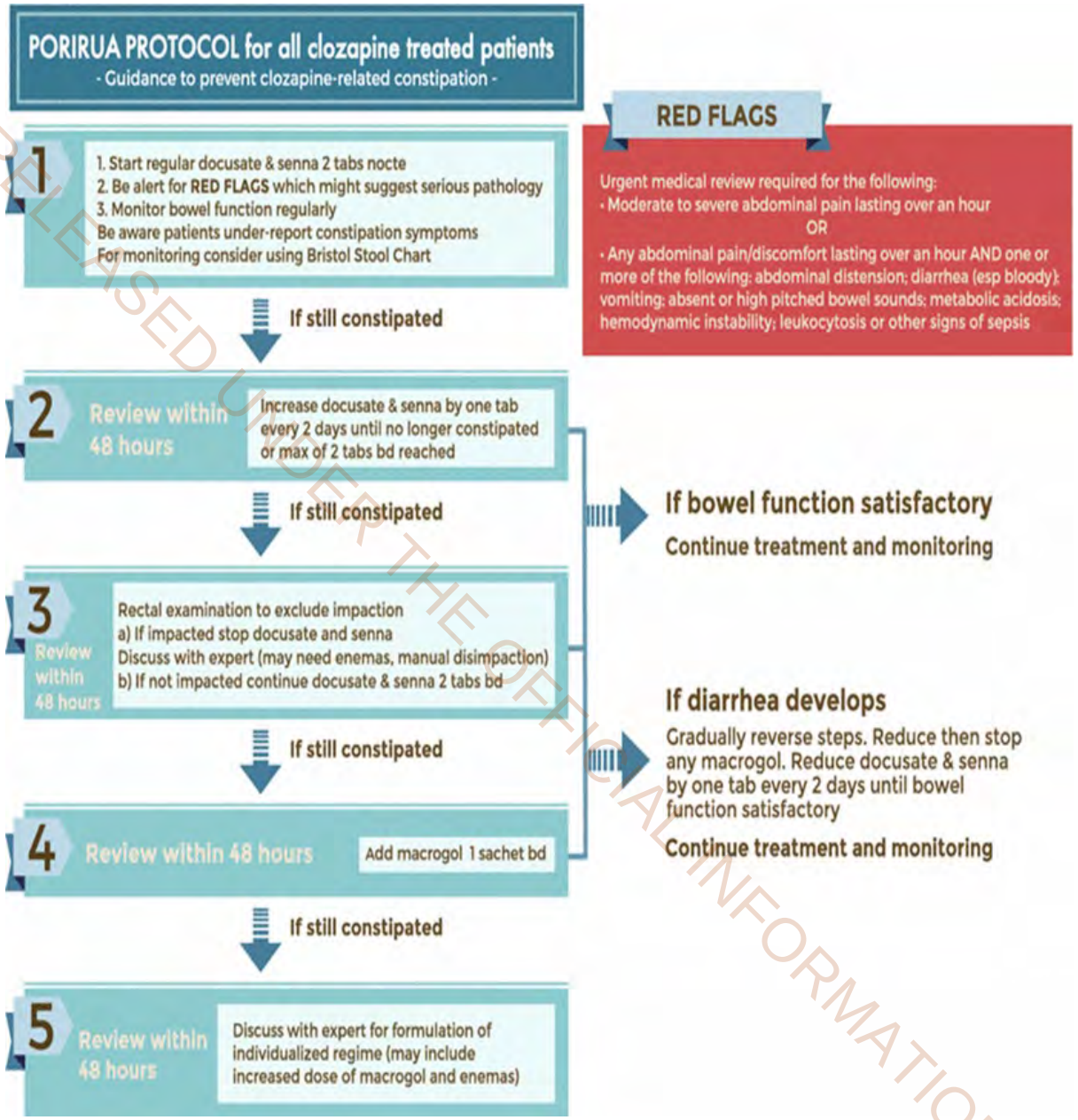
DAY	AM DOSE (mg)	PM DOSE (mg)
1		12.5
2	12.5	12.5
3	25	25
4	25	25
5	50	50
6	50	50
7	75	75
8	75	75
9	100	100
10	100	100
11	125	125
12	125	125
13	150	150
14	150	150

Higher doses may be given in the evening if drowsiness during the day is a problem. It is recommended that no more than 200mg is given as the night dose during the early titration phase. An alternative regimen may look something like this

DAY	AM DOSE (mg)	PM DOSE (mg)
1		12.5
2	12.5	12.5
3	25	25
4	25	25
5	25	75
6	25	75
7	50	100
8	50	100
9	75	125
10	75	125
11	100	150
12	100	150
13	100	200
14	100	200

After achieving a total daily dose of 300mg it is recommended that further increments be limited to 50-100mg with a maximum of 2 increases per week. Extra caution is needed in the elderly, and where there is renal, hepatic or cardiovascular impairment. For these patients the dose starts at 12.5mg daily and is increased more slowly, no more than 25mg at a time. Such cases generally require lower maintenance doses. Patients/Tangata Whaiora with a history of epileptic seizures also require extra care.

Appendix 6 – Porirua Protocol Flowchart



Appendix 7 – Discontinuation Notice

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Notice of Discontinuation of Clozaril® (clozapine) therapy

Name of Patient

NHI Number Date of Birth / /

Mental Health Unit

Prescribing Consultant/Registrar

Date *Clozaril* Treatment Discontinued / / Last *Clozaril* tablet daily dose / /

Other Medications

Reason for Discontinuation:

- ☐ Non-Compliance with; Medication ☐ Blood Tests ☐
- ☐ Lack of Efficacy – i.e. the patient received adequate doses of *Clozaril* tablets or an adequate period of time to assess the clinical efficacy of *Clozaril* therapy
- ☐ Adverse Drug Event (please describe)

  Was the adverse event considered to be related to *Clozaril* treatment? Yes ☐ No ☐
- ☐ Death (please provide cause of death)

  Was the patient's death considered to be related to *Clozaril* treatment? Yes ☐ No ☐
- ☐ Other (please specify)

Name

Signature Date / /

Please complete and forward this form to CareLink Plus.

Email carelinkplus@viatris.com

Post PO Box 11183
Ellerslie
Auckland 1542

Phone 0800 535 020

NB. This information is treated as confidential and used to update CareLink Plus.

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CareLink PLUS | Clozaril® (clozapine)

Appendix 7 – Discontinuation Notice (continued)

Privacy Statement: Viatris Limited ('Viatris New Zealand') collects and holds, uses, and discloses personal information, such as name and contact details of patients and healthcare professionals ('HCPs') and the health information of patients, for the purpose of operating and administering the *Clozaril* patient blood monitoring program ('Program') for participating patients on the Carelink Plus database ('Database'). This includes registering HCPs and patients on the Database, storing patients' blood tests, monitoring patients' use of the products, communicating with HCPs and patients about the products to support the administration and use of the products, complying with regulatory obligations (including the reporting and processing of adverse events patients may experience), and sending invitations to participate or arranging for participation in activities managed by or on behalf of Viatris New Zealand. Viatris New Zealand may need to disclose this personal information to its third party services providers and affiliates, who may be located overseas, for these purposes, and personal information in the Database is held on Viatris New Zealand's behalf in servers located overseas in the UK and/or Ireland. By providing your personal information to Viatris New Zealand, you agree that you understand this Privacy Statement. If you are an HCP, you consent to Viatris communicating with you to facilitate the transmittal of invitations to participate or arranging to participate in activities managed by or on behalf of Viatris New Zealand. Viatris is committed to patient safety. In accordance with regulatory obligations, Viatris has a systematic process in place to collect, store, and process reports of adverse events experienced by patients taking a Viatris product, when identified by a Viatris representative (or by a third party acting on behalf of Viatris). All information forwarded to the Viatris drug safety department is treated in accordance with local privacy laws and may be captured and processed in countries outside of the jurisdiction in which it was collected, and shared with health authorities or other pharmaceutical companies with whom Viatris has a license agreement for the purpose of meeting the regulatory requirements for reporting safety information on Viatris products. Viatris drug safety department may contact the patient's HCP to collect further information on the adverse event. You are not obliged to provide personal information. However, if you do not provide information you may not, for example, be able to participate fully in activities managed by us. You have the right to access, update or correct your personal information and/or decline to receive communications from Viatris. To find out how, please refer to our: Privacy Policy https://www.viatris.com/en-nz/lm/new-zealand/viatris-privacy-notice or contact Viatris New Zealand, PO Box R1462, Royal Exchange Post Office, NSW, Australia 1225. Email: dataprivacy_JANZ@viatris.com

***Clozaril* (clozapine) 25 milligrams, 100 milligrams tablets.** Prescription Medicine. Indicated for treatment-resistant schizophrenia in adult patients. Review the datasheet (available from www.medsafe.govt.nz) for information on dosage, contraindications, precautions, interactions, and adverse effects. Prescriber restrictions apply. Persons prescribing clozapine must comply with appropriate local treatment guidelines. *Clozaril* is a Viatris company trademark. Viatris Limited, Auckland. Ph 0800 579 811. CLZ-2022-0110. TAPS DA2211RY-0703. Last updated August 2022.

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Appendix 8 – Notice of Transfer Form

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Notice of Transfer of a patient on Clozaril® (clozapine) therapy

Name of Patient _____

NHI Number _____ Date of Birth ___/___/___

Transferred to (Service) _____

Transferred to (Doctor) _____

Date of Transfer ___/___/___

Comments: _____

_____

_____

_____

Name of the Person Completing this Form: _____

Please complete and forward this form to CareLink Plus.

Email
carelinkplus@viatris.com

Post
PO Box 11183
Ellerslie
Auckland 1542

Phone
0800 535 020

NB. This information is treated as confidential and used to update CareLink Plus.

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CareLink PLUS | Clozaril® (clozapine)

Appendix 8 – Notice of Transfer Form (continued)

Privacy Statement: Viatris Limited ('Viatris New Zealand') collects and holds, uses, and discloses personal information, such as name and contact details of patients and healthcare professionals ('HCPs') and the health information of patients, for the purpose of operating and administering the *Clozaril* patient blood monitoring program ('Program') for participating patients on the Carelink Plus database ('Database'). This includes registering HCPs and patients on the Database, storing patients' blood tests, monitoring patients' use of the products, communicating with HCPs and patients about the products to support the administration and use of the products, complying with regulatory obligations (including the reporting and processing of adverse events patients may experience), and sending invitations to participate or arranging for participation in activities managed by or on behalf of Viatris New Zealand. Viatris New Zealand may need to disclose this personal information to its third party services providers and affiliates, who may be located overseas, for these purposes, and personal information in the Database is held on Viatris New Zealand's behalf in servers located overseas in the UK and/or Ireland. By providing your personal information to Viatris New Zealand, you agree that you understand this Privacy Statement. If you are an HCP, you consent to Viatris communicating with you to facilitate the transmittal of invitations to participate or arranging to participate in activities managed by or on behalf of Viatris New Zealand. Viatris is committed to patient safety. In accordance with regulatory obligations, Viatris has a systematic process in place to collect, store, and process reports of adverse events experienced by patients taking a Viatris product, when identified by a Viatris representative (or by a third party acting on behalf of Viatris). All information forwarded to the Viatris drug safety department is treated in accordance with local privacy laws and may be captured and processed in countries outside of the jurisdiction in which it was collected, and shared with health authorities or other pharmaceutical companies with whom Viatris has a license agreement for the purpose of meeting the regulatory requirements for reporting safety information on Viatris products. Viatris drug safety department may contact the patient's HCP to collect further information on the adverse event. You are not obliged to provide personal information. However, if you do not provide information you may not, for example, be able to participate fully in activities managed by us. You have the right to access, update or correct your personal information and/or decline to receive communications from Viatris. To find out how, please refer to our: Privacy Policy https://www.viatris.com/en-nz/lm/new-zealand/viatris-privacy-notice or contact Viatris New Zealand, PO Box R1462, Royal Exchange Post Office, NSW, Australia 1225. Email: dataprivacy_JANZ@viatris.com

***Clozaril* (clozapine) 25 milligrams, 100 milligrams tablets.** Prescription Medicine. Indicated for treatment-resistant schizophrenia in adult patients. Review the datasheet (available from www.medsafe.govt.nz) for information on dosage, contraindications, precautions, interactions, and adverse effects. Prescriber restrictions apply. Persons prescribing clozapine must comply with appropriate local treatment guidelines. *Clozaril* is a Viatris company trademark. Viatris Limited, Auckland. Ph 0800 579 811. CLZ-2022-0110. TAPS DA2211RY-0703. Last updated August 2022.

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Appendix 9 – GP Referral Letter

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GP REFERRAL LETTER

Date ……. /…… /……

Dear Dr……

Your patient …….. is taking clozapine, an antipsychotic, which can be effective in patients who have failed to respond to, or are intolerant of, other neuroleptics.

The risk of agranulocytosis (about 0.7%) and neutropenia (about 3%) mean regular blood monitoring must be carried out for the duration of treatment with clozapine. White blood cell counts and absolute neutrophil counts are required weekly for the first 18 weeks of therapy (85% of cases occur during this period) and at least every 4 weeks thereafter throughout treatment. Monitoring must continue throughout treatment and for 4 weeks after complete discontinuation of clozapine.

If infection occurs or blood tests indicate a significant drop in white cells, a repeat test should be carried out. A significant drop is a white blood cell count falling below 3.5 x 10^9/L in the first 18 weeks of treatment or below 3.0 x 10^9/L beyond week 18, or a single drop of ε 3 x 10^9/L or a cumulative drop ε 3 x 10^9/L within three weeks compared with the pre- clozapine baseline WBC.

Should this occur immediately consult. .....
The Clozaril(clozapine) Clinical Support Technician may also be contacted on 0800 838 909.

At each consultation a patient receiving clozapine should be reminded to contact the treating physician immediately if any kind of infection begins to develop. Particular attention should be paid to flu-like complaints, such as fever or sore throat, and to other evidence of infection which may be indicative of neutropenia.

Each time the patient has a blood test done it is **important** to request that a copy be sent to both the dispensing pharmacy and Mylan New Zealand Limited. This ensures that the pharmacist can check the results before the medication is dispensed and blood results are also maintained on the Clozaril(clozapine) CarelinkPlus database. It is a condition of the supply of clozapine that all patients are registered on the Clozaril CareLinkPlus database.

Clozapine is a continuous therapy. If clozapine is not taken for more than **two days** for whatever reason, it is important to consult the data sheet section on “Re-starting therapy”. The full clozapine data sheet can be downloaded at www.medsafe.govt.nz . If a single dose has been missed, and the patient’s next dose is due within 4 hours, the missed dose is skipped and the next dose taken at the usual time. Otherwise, the missed dose should be taken as soon as the patient remembers, and then go back to taking it as they would do normally. The patient should not take a double dose to make up for the one that was missed.

It may be advantageous to counsel the patient about the importance of taking their medication regularly and the importance of regular blood monitoring. The next supply of clozapine can only be dispensed if the result from a recent blood test (<72 hours) is within the normal range.

The clozapine prescribing criteria has recently changed to allow general practitioners to continue the prescribing of clozapine for a specific patient whose illness is well-controlled in collaboration, or following consultation, with a Community Mental Health Team. Should you opt to write your patient’s follow up prescriptions for clozapine, please ensure that patient’s Consultant or Community Mental Health Team is consulted at all stages.

Should you have any queries please consult …… (Psychiatrist’s name).

Yours sincerely,

Dr……

Appendix 10 - Clozapine Monograph

Clozapine Drug Monograph (abridged): *for complete reference refer to Medsafe datasheet*

Drug	**Clozapine**
Pharmacology	It has weak dopamine receptor-blocking activity at D1, D2, D3 and D5 receptors, but shows high potency for the D4 receptor, in addition to potent anti-alpha-adrenergic, anticholinergic, antihistaminic, and arousal reaction-inhibiting effects. It has also been shown to possess antiserotoninergic properties.
Pharmacokinetics	The absorption of orally administered clozapine is 90% to 95%; neither the rate nor the extent of absorption is influenced by food. Clozapine is subject to first-pass metabolism, with a bioavailability of 50% to 60%. In steady-state conditions, when given twice daily, peak blood levels occur on an average at 2.1 hours (range: 0.4 to 4.2 hours), and the volume of distribution is 1.6 L/kg. Clozapine is approximately 95% bound to plasma proteins. This means the terminal half-life is 12 hours (range: 6 to 26 hours). Clozapine is almost completely metabolised before excretion. Of the main metabolites only the desmethyl metabolite was found to be active.
Indications	Clozapine is indicated for patients with treatment-resistant schizophrenia, i.e. patients with schizophrenia who are non-responsive to or intolerant of classic antipsychotics. **Non-responsiveness** is defined as a lack of satisfactory clinical improvement despite the use of adequate doses of at least two marketed antipsychotics prescribed for adequate durations. **Intolerance** is defined as the impossibility of achieving adequate clinical benefit with classic antipsychotics because of severe and untreatable neurological adverse reactions (extrapyramidal side effects or tardive dyskinesia).
Presentation	• Tablets containing 25 mg and 100 mg clozapine. • Clozapine 25mg tablets are light yellowish, round, flat with bevelled edges. It is scored with markings LO on one side, SANDOZ on the other side and 6.3mm in diameter. • Clozapine 100mg tablets are light yellowish, round, flat with bevelled edges. It is scored with markings ZA on one side, SANDOZ on the other side and 10mm in diameter.
Route	Oral
Dose	**Starting therapy** 12.5 mg (half a 25-mg tablet) once or twice on the first day, followed by one or two 25 mg tablets on the second day. If well tolerated, the daily dose may then be increased slowly in increments of 25 mg to 50 mg in order to achieve a dose level of up to 300 mg/day within 2 to 3 weeks. Thereafter, if required, the daily dose may be further increased in increments of 50 mg to 100 mg at half-weekly or, preferably, weekly intervals.

Appendix 10 – Clozapine Monograph (continued)

Contraindications	• Known hypersensitivity to *clozapine* or to any of the excipients of Clozapine. • Patients unable to undergo regular blood tests. • History of toxic or idiosyncratic granulocytopenia/agranulocytosis (with the exception of granulocytopenia/agranulocytosis from previous chemotherapy). • Impaired bone marrow function. • Uncontrolled epilepsy. • Alcoholic and other toxic psychoses, drug intoxication, comatose conditions. • Circulatory collapse and/or CNS depression of any cause. • Severe renal or cardiac disorders (e.g. myocarditis). • Active liver disease associated with nausea, anorexia or jaundice; progressive liver disease, hepatic failure. • Paralytic ileus.
Precautions	• Previously adverse reaction to clozapine • Drugs known to depress bone marrow function should not be used concurrently with Clozapine. • Concomitant use of long-acting depot antipsychotics should be avoided. • Patients with a history of primary bone marrow disorders Patients who have low WBC counts because of benign ethnic neutropenia
Adverse effects	• **Blood and lymphatic system disorders** • Common: Leukopenia/decreased WBC/neutropenia, eosinophilia, leukocytosis • Uncommon : Agranulocytosis • Rare: Anaemia • Very rare: Thrombocytopenia, thrombocythaemia • **Metabolism and nutrition disorders** • Common: Weight gain • Rare : Impaired glucose tolerance, new onset diabetes, diabetes aggravated • Very rare: Ketoacidosis, hyperosmolar coma, severe hyperglycaemia, hypercholesterolaemia, hypertriglyceridaemia • **Psychiatric disorders** • Common :Dysarthria • Uncommon: Dysphemia • Rare : Restlessness, agitation • **Nervous system disorders** • Very common: Drowsiness/sedation, dizziness • Common: Blurred vision, headache, tremor, rigidity, akathisia, extrapyramidal symptoms, seizures/convulsions/myoclonic jerks • Rare : Confusion, delirium • Very rare Tardive dyskinesia, obsessive compulsive symptoms • **Cardiovascular disorders** • Very common: Tachycardia • Common: ECG changes • Rare : Circulatory collapse, arrhythmias, myocarditis, pericarditis • Very rare: Cardiomyopathy • **Vascular system disorders** • Common: Hypertension, postural hypotension, syncope • Rare : Thromboembolism

Prescribing and Monitoring Clozapine Treatment

Appendix 11 - Clozapine Significant Side Effects and Management Advice

For full side effect list please refer to data sheet

1	***Sedation***	Re-adjust dose if persistent and/or re-adjust dose scheduling. Common in the early stages of dose titration.
2	***Hypersalivation***	This might respond to dose reduction. Alternative treatments may include anticholinergics (e.g. benztropine), clonidine or alpha-antagonists such as terazosin. Sub-lingual sprays of anti-cholinergics can be helpful, e.g. Ipratropium Inhaler.
3	***Hyperthermia***	Transient benign hyperthermia is not uncommon during the first three weeks of treatment with clozapine. It usually involves an increase of 0.5 - 1.5^{o}C that spontaneously resolves over a few days with continued clozapine treatment. Temperature elevations above 38.5^{o}C may require temporarily withholding of clozapine and further investigation for other causes.
4	***Tachycardia***	Common side effects that can affect a significant percentage of patients. Slow dose titration may reduce the risk of emergence of this side effect. It usually responds to dose reduction. If tachycardia persists, atenolol or metoprolol are usually effective in managing the tachycardia. ECG is required if tachycardia persists or is accompanied by raised CK level. Persistent tachycardia accompanied by high CK and eosinophilia might indicate the presence of myocarditis. In severe cases clozapine treatment must be discontinued.
5	***Hypotension***	Clozapine can lead to a postural drop in blood pressure.
6	***Constipation***	This is a common side effect which should be detected early and adequately treated. It usually responds to stool softeners, laxatives, fibre supplements and adequate fluid intake. Failure to treat constipation could result in serious complications such as toxic megacolon and aspirational pneumonia.
7	***Haematological side effects***	• Neutropenia 2.6%. • Leucocytosis can affect about 0.6% of patients. • Eosinophilia can affect up to 1% of patients. If eosinophil count is above 3.0 x 10^{9}/L discontinue treatment. High eosinophil count specially if associated with tachycardia is a possible indication of an underlying myocarditis. • Agranulocytosis - affects about 0.8% of patients in the first year and declines in subsequent years. • Thrombocytopenia - Platelet count below 100 x 10^{9}/L is associated with a high risk of bleeding. Clozapine should be discontinued if it drops below 50 x 10^{9}/L. • Lymphopenia - rare side effect. Discontinue if lymphocyte count is below 0.5 x 10^{9}/L.
8	***Myocarditis and Cardiomyopathy***	Rare but serious side effect. Myocarditis usually develops during the first few weeks of clozapine treatment, but cardiomyopathy may occur at any time. Warning symptoms include malaise, fatigue, chest pain, palpitations, dyspnoea and fever. Sometimes these symptoms are accompanied by peripheral eosinophilia. If a patient is suspected to have myocarditis, clozapine treatment must be terminated. An association between eosinophilia and myocarditis has been well documented however an association between myocarditis and clozapine induced eosinophilia has not been well established.
9	***Myoclonic jerks***	Responds to dose reductions. Sodium Valproate is effective in persistent cases and usually prevents progression to generalised seizures.

Appendix 11 – Clozapine Significant Side Effects and Management Advice (continued)

10	***Seizures***	This is a dose related side effect which is more commonly associated with clozapine than with traditional antipsychotic medications, especially at doses over 450mg/day. This is another good reason for establishing the lowest possible dose of clozapine. Patients with pre-existing epilepsy can only be prescribed clozapine if their condition is stable.
11	***Neuroleptic Malignant Syndrome (NMS)***	This has been reported, though rarely, with clozapine treatment.
12	***Hyperglycaemia***	This is a rare side effect which has been reported in patients on clozapine treatment.
13	***Weight Gain***	Considerable weight gain can be a significant problem in some patients. Advice on diet and exercise should be given when the patient commences therapy.

Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Acute Adult and Forensic and MHSOP clinical staff
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Te Whatu Ora Health New Zealand assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Chris Huxtable and Carole Kennedy	June, July 2015	Mental state examination Review of the shift leader / ACNM description Audit indicators
03	Carole Kennedy	October 2018	DASA updated EWS updated and removed ADDS Updated the MSE to World Health Organisation References and links included SBARR and shift lead updated
04	Kylie Balzer	July 2023	Document expanded to include clinical handovers and other clinical communication strategies based on communication of risk, aimed at decreasing adverse events, and providing high quality care delivery

Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff

Contents

Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff

1 Overview

1.1 Purpose

The purpose of this guideline is to provide best practice communication principles and strategies for use in clinical practice within teams in the mental health environment in the acute adult, forensic and Mental Health Services for the Older Person (MHSOP).

This guideline will outline principles of practice for:

1. Clinical handovers in transitions of care delivery
2. Communication and escalation of risks within the team and multidisciplinary team
3. Strategies for overcoming barriers to effective communication

Effective communication between mental health clinical staff is essential for the communication of risk, providing high quality care, and reducing the risk of adverse events.

The implementation of this guideline will respect and uphold the principles under Te Tiriti o Waitangi.

All mental health and addictions staff are required to follow the requirements of the Te Whatu Ora Waikato Admission, Discharge and Transfer policy (1848).

1.2 Staff group

All staff working in clinical practice in the acute adult and forensic and MHSOP service.

1.3 Patient / client group

This guideline will support safe and effective team communication to enhance safety for tāngata whaiora receiving care delivery within the Acute Adult and Forensic and MHSOP service.

1.4 Exceptions / contraindications

This guideline does not specifically cover communication strategies with tāngata whaiora or whānau / key support persons. The guideline is intended to cover strategies in clinical team communication during practice delivery. This guideline does not cover clinical supervision processes, diffusion, or debriefs.

1.5 Definitions and acronyms

Clinical handovers	The transfer of professional responsibility and accountability for some or all aspects of care for a tāngata whaiora, or group of tāngata whaiora to another health professional or professional group on a temporary or a permanent basis. The clinical handover process does not reduce the need for comprehensive documentation in the tāngata whaiora clinical record.

Communication strategies	Strategies used in communication to provide the effective transfer and understanding of information
Dynamic Appraisal of Situational Aggression (DASA)	Dynamic Appraisal of Situational Aggression (DASA) is a tool to assess the likelihood that a tāngata whaiora will become aggressive within a psychiatric inpatient environment.
Handover sheet	A tool used by clinical staff members as an informal record to guide the delivery of care throughout the shift. The handover sheet is an informal record and are not subject to the clinical record retention requirements.
Huddles	Huddles are a brief stand up meeting that are structured and focused on enhanced staff communication and tāngata whaiora safety.
Mental State Examination	"Mental state examination involves assessment of the person's appearance, behaviour, conversations (through form and content), affect and mood, perception, cognition, insight and judgement." Terry Froggatt and Susan Sumskis (p.100, 2017)
SBARR	SBARR is a communication tool that provides a common and predictable structure to clinical communication. SBARR is the format used for clinical handovers, and can be used for communicating urgent situations or when requesting a review or escalation of care

2 Clinical management

2.1 Roles and responsibilities

Clinical staff

All staff in clinical practice need to be aware of and utilise best practice communication practices within their roles.

All clinical staff are to provide support to the clinical handover process and shared communication within their ward / area of practice.

Managers

Charge Nurse Managers need to ensure that best practice communication practices, and the processes for these within their context of care are a part of the orientation process for their ward / area.

Staff required to lead the clinical handover process need to specifically be oriented to the role of shift handover leadership, and role model the best practice processes for clinical handover.

Monitoring of communication practices is to be a part of the quality improvement processes within wards / areas, and feedback provided to staff at the ward / area team meetings.

Clinical Leadership roles

Best practice communication practices are to be promoted and supported by clinical leadership roles to advance their integration into practice.

2.2 Competency required

Staff are to have been provided information on this guideline and the current best practice communication processes specific to their area of practice within the ward / area during orientation.

Speaking up for Safety is a mandatory requirement for staff to attend in person training during orientation.

2.3 Equipment

- PFM boards
- Handover sheets as identified by the specific context of care
- Clinical workstation

2.4 Guideline

2.4.1 Clinical Handovers in transitions of care delivery

Clinical handovers occur constantly between shifts, during shifts e.g. when staff are going on meal break, on transfer between wards, discussion of care in a multidisciplinary team meetings, and on transfer between services e.g. to another unit or facility; to the community setting; and when the tāngata whaiora is going to an appointment or procedure. A standardised approach to clinical handovers is known to benefit the safety of tāngata whaiora, with flexibility being important for the delivery of relevant information to be adapted to the context of the service and situation.

Clinical handovers are an explicit transfer of clinical accountability and responsibility and not just the transfer of information. Clinical handovers include the handover of specific risks and needs for the individual tāngata whaiora, whānau and key support persons.

Whilst clinical handovers often occur within the nursing discipline, they may include any members of the multidisciplinary team as appropriate.

Handovers between shifts

Clinical handovers between shifts are the transfer of relevant tāngata whaiora information verbally that is required to transfer responsibility and accountability of care to the next shift. The relevancy of information to be communicated is based on the transfer of the responsibility and accountability of care delivery.

Clinical handovers are to be held in an area where information can be confidentially transferred and where there is access to the information on the PFM boards. The environment for clinical handover is to be respected and one in which disruptions and interruptions are minimised.

The clinical handover process is to have a designated lead person who may be a CNM / ACNM / CNS or a designated shift lead. Allocation of tāngata whaiora to staff needs to take into account continuity of care provision, and the acuity needs of the tāngata whaiora. The role of the clinical handover lead is to guide the staff to be punctual to

handover, concise and on-topic in their handover delivery, and promoting the environment that supports the delivery of key information appropriate to clinical handover.

The clinical handover is to be person centred based and utilise positive language (e.g Real language, real hope on the Te Pou website

https://d2ew8vb2gktr0m.cloudfront.net/files/resources/Real-language-real-hope.pdf

and positive words as identified within the Safewards programme who identify “In order to balance that natural tendency, we suggest that something positive is said about each patient at the handover, and that when difficult behaviour is described, potential psychological explanations are also offered. This will promote the positive appreciation of patients and reduce the likelihood of further conflict.” (Safewards website Accessed 17 July 2023)

Clinical handover content is to be clear, concise, and use easily understood words with the minimal use of Te Whatu Ora Waikato accepted abbreviations. All inpatient handovers are to include a verbal component with the current responsible member of the clinical staff speaking directly to a receiving member of the team taking over responsibility and accountability.

All tāngata whaiora are to be handed over during the clinical handover process and the process is to include the identification of any tāngata whaiora of concern and any newly admitted tāngata whaiora.

Te Whatu Ora Waikato uses the SBARR format for clinical handovers organisationally as per the Te Whatu Ora Waikato SBARR Communication Tool Guideline (5038).

As per the requirements of the Te Whatu Ora Waikato Medicines Management Policy (0138) the national medication chart and any other medication charts in use require to be reviewed by incoming staff with outgoing staff to ensure that the medication requirements of each patient are understood and any discrepancies or concerns are identified. Completion of any medication or treatment omissions can then be noted and planned for.

The first component of the handover will be the introduction of the tāngata whaiora by name and relevant identification details e.g. age. Please ensure that the information provided as to the tāngata whaiora identification cannot be confused with other tāngata whaiora on the ward. Patient Identification as part of the clinical handover process is as per the requirements of the Te Whatu Ora Waikato Patient Identification Policy (1539).

The following is a guideline to what may be covered within the SBARR format within the context of a mental health ward / area:

Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff

Structure: SBARR	Content handover item (minimum)	
Background	Clinical status	Includes relevant mental and physical clinical history, current diagnosis and mental state exam. Key alerts and allergies to be provided.
	Summary of KEY nursing interventions	Includes completed and recommended interventions e.g. PRN medications Oversight of the medication chart is to be a part of the clinical handover process.
Assessment	Risk level and management strategies Physical health risks	Risk levels are only useful if qualified and include management strategies Risk communication will include current mental health risk, appropriate historical risk, Dynamic Appraisal of Situational Aggression (DASA), assessment and any interventions Management strategies based on physical health risks e.g. diabetes, falls harm prevention, VTE risks
	Social interactions	Observations and any changes
	Tāngata whaiora / Key support person requests	e.g. diet, activities / programmes, visits. Any follow up requirements.
	Changes to recovery / treatment plan	e.g. pending and reviewed investigation results for follow up; changes in medication; changes in discharge planning specific plans for the day and responsibilities e.g. MHA review – psychiatrist, whānau meeting, team meeting, hospital appointment Outcomes from multidisciplinary team meetings Referrals to external agencies, other disciplines
Recommendations	Care instructions	- Legal status and when review due date - Leave status - Levels of observation - Level of care delivery - Key risk factors and critical information
Response		Understanding confirmed and includes the current plan for the shift, highlighting key priorities

(Adapted from the work of Cowan et. al 2018)

A handover sheet may be completed by nursing staff for their use during the shift. As identified in the Releasing Time to Care Shift Handover module "Standardised handover information sheets keep handover information consistent, help avoid gaps and can be customised to reflect the information staff have said they most need at handover".

Following the handover transfer of care a face to face introduction to the allocated registered nurse and other staff as appropriate involved in the tāngata whaiora care is to occur. This mihi (greeting / introduction) is to create a relationship / connection with the tāngata whaiora, and to become aware of any pressing needs of the tāngata whaiora / key support persons. As required an interpreter should be made available as per the Te Whatu Ora Waikato Interpreters and Translation procedure (0137).

See the appendix A for key principles to follow in the clinical handover process.

Handovers of tāngata whaiora within the hospital (for procedure, treatment, or to another ward)

The following apply to the transfer of tāngata whaiora within the hospital environment:

- All tāngata whaiora transferred from one clinical area to another clinical area require the handover of care to be documented in the clinical record. This includes details of the transfer time indicating a transfer of professional responsibility and accountability.
- Patient Identification processes occur as per the Te Whatu Ora Waikato Patient Identification Policy (1539)
- The SBARR format is used for handover
- Clinical alerts are identified e.g. FYI flags, allergies, infection prevention and control precautions, EWS modification, Not For Resuscitation (NFR) status
- Significant current risks
- The designated levels of observation are maintained as per the Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services Procedure (5238)
- As required an interpreter should be made available as per the Te Whatu Ora Waikato Interpreters and Translation procedure (0137)
- The health professional providing the handover of care is fully aware of the current risks and needs of the individual tāngata whaiora
- Awareness of the cognitive, emotional, and psychological needs and support required for tāngata whaiora during the transfer process
- Any checklists / documents required within the transfer of care process are completed

Handovers to Community Services and External Services

In addition to the above requirements for handovers for transfers within the hospital the requirements for discharge as detailed in the Te Whatu Ora Admission, Discharge and Transfer policy (1848) must be met.

2.4.2 Communication and escalation of risks within the multidisciplinary team

Communication and escalation of risk can occur throughout the shift in addition to being communicated in the clinical handover process. Mechanisms for communication of clinical risk within practice include and may not be limited to:

- The use of huddles
- Continual risk communication, documentation and escalation
- Speaking up for safety

Huddles

Huddles are brief (e.g. 10 minutes) stand up meetings involving members of the multidisciplinary team present on the ward / in the area. The goal of a huddle is to offer an opportunity for team members to coordinate care, delegate tasks, and troubleshoot issues that have arisen during a shift. Huddles provide an opportunity for current situation awareness, based on the knowledge that changes occur throughout shifts. Huddles need to be a healthy environment for staff to communicate and create an open dialogue.

Huddles held in wards are based on the discretion of the Charge Nurse Manager. Structured processes are to be in place for the staff in respect to the huddle within the context of care delivery.

The Institute for Health Care Improvement (2019) has a five item huddle agenda that can be adapted for use which includes:

1. Safety and quality concerns and successes in the past day or shift
2. Safety and quality issues for tāngata whaiora on today's schedule
3. Review of tracked issues (previously identified issues)
4. Announcements and information to share

Another way of looking at huddles is to look back on the shift, looking forward to what may happen during the shift / day and having an overall unit picture (Goldenhar, Brady, Sutcliffe, Muething, 2013)

"Look Back" – what changes have occurred since the clinical handover

"Look Forward" – what to expect for the rest of the shift based on risk / issues identified

"Integrate" – encouraging collaboration e.g. delegating of tasks, troubleshooting, and staff needs

Risk communication and documentation

At any point in the shift that new risks are identified (e.g. from conversations, clinical handover, huddles, multidisciplinary team meetings, ward rounds) these are to be documented in the tāngata whaiora clinical record, and communicated to all required members of the multidisciplinary team. CNMs / ACNMs / Shift Leads / Medical Staff must keep risk at the forefront of their thinking and promote continual situational awareness of how to mitigate, communicate and manage these risks.

As per the requirements of key procedures within the ward / area / service escalation of risk must occur to medical staff, After Hours Coordinators, the Operations Manager, and the Clinical Director. Staff must discuss with their Charge Nurse Manager during orientation the requirements for escalation pertinent to their role during orientation.

It is essential that any staff including ancillary staff are able to raise a risk, or potential risk at any time with a CNM / ACM / Shift Lead.

As per the requirements of the Early Warning Scoring System for the Deteriorating Patient Policy (1540) and Procedure (1541) the escalation of a clinically deteriorating patient must occur.

Speaking up for safety

Speaking up for safety is the Te Whatu Ora Waikato tool respectfully raising issues. Information on Speaking Up for Safety is available on the Te Whatu Ora intranet page

https://intranet.sharepoint.waikato.health.govt.nz/Pages/Speaking%20up%20for%20Safety-Have%20you%20got%20my%20back.aspx

A refresher on the C.O.D.E. (Checks, Options, Demands, Elevates) can be found here:

https://intranet.sharepoint.waikato.health.govt.nz/Pages/Speaking-Up-for-Safety-refresher.aspx

2.4.3 Strategies for overcoming barriers to effective communication

The following strategies are important for overcoming barriers in effective communication:

- Voice concerns
- Ask questions
- Share information
- Create a healthy communication environment
- Reduce interruptions and distractions
- Use structured communication tools
- Reduce jargon and the use of abbreviations
- Speak clearly and at a pace that the receiver can follow
- Check back for understanding

(Guttman et al. 2021)

3 Patient information

It is important that tāngata whaiora, and key support persons are aware of the staff caring for them on a shift, and know who to approach regarding any concerns. Tāngata whaiora need to be kept informed of any changes that occur during the shift.

4 Audit

4.1 Indicators

- 10 point checklist Shift Handovers in the Releasing Time to Care. The Productive Mental Health Ward module on shift handovers
- Issues related to communication arising from incidents and tāngata whaiora complaints

4.2 Tools

- Releasing Time to Care. The Productive Mental Health Ward Module on shift handovers
- Learning from adverse event processes

5 Evidence base

5.1 Bibliography / References

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- Releasing Time to Care. The Productive Mental Health Ward Shift Handovers Version 1.
- https://intranet.sharepoint.waikato.health.govt.nz/RefDocs/Nursing%20and%20Midwifery/Handover%20-%20releasing%20time%20to%20care.pdf
- Safewards website – Positive words https://www.safewards.net/interventions/positive-words Accessed 17 July 2023

5.2 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions AWOL (Absent Without Official Leave) procedure (3555)
- Mental Health and Addictions BAO Be Aware of – Crisis assessment and treatment service procedure (2712)
- Mental Health and Addictions Courtyards procedure (0516)
- Mental Health and Addictions Courtyards in OPR1 procedure (6441)
- Mental Health and Addictions Leave Adult Mental Health Inpatient Wards procedure (2184)
- Mental Health and Addictions Leave Puawai Inpatient Wards procedure (6266)
- Mental Health and Addictions Levels of Observation across All Mental Health and Addiction Inpatient Services procedure (5238)
- Mental Health and Addictions Professional Supervision for Registered / Enrolled Nurses in the Mental Health and Addictions Service procedure (0332)
- Mental Health and Addiction Puawai Internal Security procedure (2687)
- Mental Health and Addictions Searching of Mental Health Service Users in Relation to Illicit Substances and Dangerous Articles procedure (1862)
- Mental Health and Addictions Sexual Safety in Mental Health and Addictions Inpatient Units procedure (6265)
- Mental Health and Addictions Use of Personal Restraint in Mental Health and Addictions Inpatient Setting procedure (1865)
- Mental Health and Addictions Use of Safety Garments in Inpatient Mental Health and Addictions Service procedure (5788)
- Mental Health and Addictions Whānau Inclusive Practice guideline (5795)

- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others (5241)
- Te Whatu Ora Waikato Admission, Discharge and Transfer policy (1848)
- Te Whatu Ora Waikato Credentialling of Health Practitioners policy (0004)
- Te Whatu Ora Waikato Direction and Delegation of Enrolled Nurses policy (3003)
- Te Whatu Ora Waikato Early Warning Scoring System for the Deteriorating Patient policy (1540).
- Te Whatu Ora Waikato Early Warning Scoring System for the Deteriorating Patient procedure (1541)
- Te Whatu Ora Fall risk assessment, minimisation and management policy (1705)
- Te Whatu Ora Waikato Interpreters and Translation procedure (0137)
- Te Whatu Ora Waikato Health Care Support Worker policy (1832)
- Te Whatu Ora Waikato Medicines Management policy (0138)
- Te Whatu Ora Waikato Patient Identification policy (1539)
- Te Whatu Ora Waikato SBARR Communication Tool guideline (5038)
- Te Whatu Ora Waikato Professional Supervision for Allied Health procedure (0536)
- Te Whatu Ora Waikato Venous Thromboembolism Risk Assessment and Prophylaxis policy (1449)

5.3 External Standards

- Ngā Paerewa Health and disability services standard NZS8134:2021

Appendix A – Key principles for clinical handover

Preparation	• Allocation of tāngata whaiora • Scheduling of the clinical handover • Update clinical records, documentation, and have charts and information ready e.g. medication chart
Organisation	• Assigned lead for the clinical handover • Scheduled time for verbal handover to occur • Use of standardised clinical handover format (SBARR) • Organisation of any required personnel e.g. interpreters • Context appropriate handover documents agreed with the team are available • Organisation of the relevant staff to be present, and the ward / area to have staff coverage for safety
Environmental Awareness	• Positive environment e.g. language • Minimise interruptions and distractions • Confidentiality
Transfer of responsibility and accountability	• Ensure oncoming staff have all the information they need to take over the responsibility and accountability for the care of the tāngata whaiora – ask the incoming staff if they have any questions
Tāngata whaiora / key support person needs	• Ensure the needs of tāngata whaiora are met whilst clinical handover is in process • Provide a mihi (introduction / greeting) of oncoming staff and address any immediate current needs of tāngata whaiora • Ensure the voice of the tāngata whaiora, key support persons, and whānau is included within the clinical handover process • Complete a safety scan

Courtyards In OPR1

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Nicki Barlow
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff working in OPR1
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes

Courtyards In OPR1

Contents

Courtyards In OPR1

1 Overview

1.1 Purpose

To ensure the safety of tāngata whaiora and staff when the courtyards are being used in OPR1.

1.2 Scope

This procedure applies for the use of courtyards in OPR1 inclusive of the main courtyard and the courtyard off the HDU lounge.

1.3 Patient / client group

Tāngata whaiora in OPR1.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

SPEC	Safe Practice and Effective Communication Training

2 Clinical management

2.1 Roles and responsibilities

Clinical staff

Clinical staff will support tāngata whaiora to have reasonable access to courtyards and fresh air on a daily basis.

Clinical staff will monitor and manage safe access to courtyards in OPR1.

Charge Nurse Manager / Associate Charge Nurse Manager

Will ensure that monitoring of this procedure and associated recommendations are implemented.

2.2 Competency required

- SPEC (Safe Practice Effective Communication) training is completed
- Levels of Observation procedure self-directed learning is completed

2.3 Equipment

- Radio Transmitter (RT)
- Clinical Workstation
- DATIX incident reporting system

2.4 Procedure

2.4.1 Access to the courtyards

Tāngata whaiora may access the courtyards during daylight hours (which will change dependant on the season) and up to 2100hrs in the evening at the staff discretion. Staff will make reasonable effort to enable tāngata whaiora to have access to fresh air through the use of the courtyard, with due consideration to the time of day, weather, tāngata whaiora medical condition and current risk, and current risks within the environment.

Staff must be able to safely monitor the courtyards during use.

Tāngata whaiora may access the HDU courtyard when a staff member is present only.

Courtyard opening times are to be displayed for tāngata whaiora in each area and opening times will be included in OPR1 tāngata whaiora welcome information pack.

2.4.2 Prior to accessing courtyards

Prior to opening the courtyard for tāngata whaiora the safety of the courtyard environment will be assessed by a Registered Nurse.

2.4.3 Staff presence in courtyards

When tāngata whaiora are accessing the courtyard a minimum of one staff member must be present in the courtyard at all times.

The staff: tāngata whaiora ratio and risk is to be considered when allocating staff numbers to courtyard duty.

A staff member on courtyard duty must carry a Radio Transmitter to enable them to call for assistance if it is required.

Staff are to remain vigilant of tāngata whaiora and staff safety at all times during courtyard use. This includes ensuring that staff members are not isolated from other staff. Furthermore this includes the requirment that staff on courtyard duty will strictly NOT undertake other duties/activities whatsoever.

OPR1 actively encourages and supports Whānau of tāngata whaiora to use the courtyard as a place of calm and as a place for therapeutic intervention. When Whānau are with their tāngata whaiora in the courtyard a staff member will be present to supervise and monitor safe access.

2.4.4 Vigilance and constant assessment of Tāngata whaiora in the courtyards.

When tāngata whaiora are accessing the courtyard, staff need to maintain vigilance for early warning signs and triggers that might indicate changes and result in behaviours of concern. Staff identifying behaviour of concern must call for assistance from other staff members. A DATIX incident notification must be completed for any behaviour involving actual physical and verbal aggression, self-harm behaviours and other incidents that can result in potential or actual harm.

2.4.5 Closure of courtyards

When the ward environment is assessed as having a number of high risk tāngata whaiora in situ, where having the courtyard doors open provides an increased risk of AWOL, the courtyard doors may be locked.

This requires assessment of clinical risk, levels of observations and clinical interventions by the Charge Nurse Manager / Manager or delegate responsible for care, and the consideration of the rights of the individuals.

The multidisciplinary team must maintain awareness of the current risk of tāngata whaiora who are likely to AWOL from a courtyard.

Any incidents of AWOL from a courtyard must be documented in the tāngata whaiora progress note, risk assessment and pattern analysis mental health services document on CWS, and a DATIX incident notification completed. The mental health and addictions AWOL (Absent Without Official Leave) procedure (3555) is to be followed.

The multidisciplinary team must agree to the closure of the courtyard doors as a short term intervention.

The shift leader / Charge Nurse Manager / Manager is then responsible for informing the District Inspector and DAMHS, MHSOP Clinical Director and Operations Manager via email that the doors are required to be locked, the rationale and the anticipated timeframe.

Note: the courtyard doors will be locked overnight for security purposes.

3 Patient information

Ward expectations displayed in OPR1 inpatient ward.

4 Audit

4.1 Indicators

- Emails escalating closure of the courtyard
- DATIX incident reporting and management
- Observations of the safety of the courtyards during patient safety walk rounds

4.2 Tools

- Email monitoring by Operations Manager and Clinical Directors of courtyard closures
- DATIX incident reporting system
- Patient Safety walk rounds

5 Evidence base

5.1 Associated Waikato DHB Documents

- Clinical Records Management policy (Ref. 0182)
- Health and Safety policy (Ref. 0044)
- Incident Management policy (Ref. 0104)
- SBARR Communication Tool protocol (Ref. 5038)
- Mental Health and Addictions AWOL (Absent without Official Leave) procedure (Ref. 3555)
- Mental Health and Addictions Duress Alarm Use and Management – Inpatient Mental Health and Addictions procedure (Ref. 2681)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (Ref. 5238)
- Mental Health and Addictions Searching of Mental Health service users in relation to illicit substances / dangerous articles procedure (Ref. 1862)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (Ref. 5241)
- OPR1 Welcome Pack (FX018)
- Mental Health and Addictions risk assessment and pattern analysis document on CWS

5.2 External Standards

Include and may not be limited to:

- Health and Disability services standards NZS 8134: 2021
- Human Rights Act 1993
- Health and Safety at Work Act 2015
- Health and Disability Commissioner Act 1994
- Health Practitioner Competency Assurance Act 2003
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998

Courtyards

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff working in adult inpatient and forensic inpatient wards
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
08	Kylie Balzer	21 June 2018	RESPECT: Restraint elimination; safe practice and effective communication training Updated to revised DHB template for procedures which includes staff roles and responsibilities Amalgamation of Courtyards – Puna Awhi-rua , Puna Maatai, and Puna Poi Poi procedure (0516) and Courtyards – Adult inpatient wards 34,35, 36 Inclusion of environmental audit of courtyards Inclusion of section from Inpatient Acute Adult Metnal Health wards process for entry and exit of wards procedure (3155)
		January 2019	Use of courtyards when high care lounge in Puna Awhi-rua and Puna Maatai at the discretion of the Charge Nurse Manager When court is in progress Ward 36 courtyard is not used
09	Kylie Balzer	September 2021	Updated to reflect changes in the environment and learnings from incidents Change from action / rationale format as no longer accepted by Quality and Patient Safety

Courtyards

Contents

Courtyards

1 Overview

1.1 Purpose

To ensure the safety of tāngata whaiora and staff when the courtyards are being used in the Henry Rongomau Bennett Centre.

1.2 Scope

This procedure applies for the use of courtyards in Mental Health and Addiction inpatient Forensic wards: Puna Awhi-rua, Puna Maatai and Puna Poi Poi, Mental Health adult inpatient wards 34, 35, 36 and 41.

1.3 Patient / client group

Tāngata whaiora in Adult and Forensic mental health inpatient wards.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

SPEC	Safe Practice and Effective Communication Training

2 Clinical management

2.1 Roles and responsibilities

Clinical staff
Clinical staff will support tāngata whaiora to have reasonable access to courtyards and fresh air on a daily basis.

Clinical staff will monitor and manage safe access to courtyards in the inpatient wards.

Charge Nurse Managers
Will ensure that monitoring of this procedure and associated recommendations are implemented.

2.2 Competency required

- SPEC (Safe Practice Effective Communication) training is completed
- Levels of Observation procedure self-directed learning is completed

2.3 Equipment

- Duress
- Radio Transmitter (RT)
- Clinical Workstation
- DATIX incident reporting system

2.4 Procedure

2.4.1 Access to the courtyards

Tāngata whaiora may access the courtyards during daylight hours (which will change dependant on the season) and up to 2100hrs in the evening at the staff discretion. Staff will make reasonable effort to enable tāngata whaiora to have access to fresh air through the use of the courtyard, with due consideration to the time of day, weather, tāngata whaiora medical condition and current risk, and current risks within the environment.

Staff must be able to safely monitor the courtyards during use.

In Puna Awhi-rua and Puna Maatai – when either high care lounges are in use the internal courtyard is in use at the discretion of the Charge Nurse Manager / delegate. This is to ensure privacy and dignity of individuals using the high care lounge.

In Ward 36 when court is in process the Ward 36 courtyard is not to be utilised.

Courtyard opening times are to be displayed for tāngata whaiora in each area.

2.4.2 Prior to accessing courtyards

Prior to opening the courtyard for tāngata whaiora all other doors leading into the courtyard (for meeting room and whānau room doors in adult, and Occupational therapy door in Puna Awhi-rua and Puna Maatai) must be checked and must be locked at all times.

Searching of the courtyard for illicit substances and / or hazardous items prior to tāngata whaiora accessing the courtyard and after exiting the courtyard is the staff responsibility. If illicit substances / hazardous items are located a DATIX incident notification must be completed.

2.4.3 Staff presence in courtyards

When tāngata whaiora are accessing the courtyard a minimum of one staff member per ward must be present in the courtyard at all times.

The staff: tāngata whaiora ratio and risk is to be considered when allocating staff numbers to courtyard duty.

The staff member/s on courtyard duty will carry a duress and Radio Transmitter to enable them to call for assistance if it is required.

Staff are to remain vigilant of tāngata whaiora and staff safety at all times during courtyard use. This includes ensuring that staff members are not isolated from other staff.

2.4.4 Vigilance of potential presence of illicit and / or hazardous substances / items

When tāngata whaiora are accessing the courtyard, staff need to maintain vigilance regarding the potential to pass illicit and / or hazardous substances / items. Staff identifying this behaviour must call for assistance from other staff members. A DATIX

incident notification must be completed for any behaviour involving the passing of illicit and / or hazardous substances.

2.4.5 Closure of courtyards

When the ward environment is assessed as having a number of high risk tāngata whaiora in situ, where having the courtyard doors open provides an increased risk of AWOL, the courtyard doors may be locked.

This requires assessment of clinical risk, levels of observations and clinical interventions by the Charge Nurse Manager / Manager or delegate responsible for care, and the consideration of the rights of the individuals.

The multidisciplinary team must maintain awareness of the current risk of tāngata whaiora who are likely to AWOL from a courtyard.

Any incidents of AWOL from a courtyard must be documented in the tāngata whaiora progress note, risk assessment and pattern analysis mental health services document on CWS, and a DATIX incident notification completed. The mental health and addictions AWOL (Absent Without Official Leave) procedure is to be followed.

The multidisciplinary team must agree to the closure of the courtyard doors as a short term intervention.

The shift leader / Charge Nurse Manager / Manager is then responsible for informing the District Inspector and DAMHS, Adult Clinical Director and Operations Manager via email that the doors are required to be locked, the rationale and the anticipated timeframe.

Note: the courtyard doors will be locked overnight for security purposes.

3 Patient information

Ward expectations displayed in the adult inpatient wards and forensics.

4 Audit

4.1 Indicators

- Emails escalating closure of the courtyard
- DATIX incident reporting and management
- Observations of the safety of the courtyards

4.2 Tools

- Email monitoring by Operations Manager and Clinical Directors of courtyard closures
- DATIX incident reporting system
- Patient Safety walk rounds

5 Evidence base

5.1 Associated Waikato DHB Documents

- Waikato DHB Clinical Records Management policy (0182)
- Waikato DHB Health and Safety policy (0044)
- Waikato DHB Incident Management policy (0104)
- Waikato DHB SBARR Communication Tool guideline (5038)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (5238)
- Mental Health and Addictions Searching of Mental Health service users in relation to illicit substances / dangerous articles procedure (1862)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Mental Health and Addictions AWOL (Absent without Official Leave) procedure (3555)
- Mental Health and Addictions Duress Alarm Use and Management – Inpatient Mental Health and Addictions procedure (2681)
- Mental Health and Addictions Use of Seclusion procedure (1860)
- Henry Rongomau Bennett Centre Information resource C1733HWF
- Mental Health and Addictions risk assessment and pattern analysis document on CWS

5.2 External Standards

Include and may not be limited to:

- Health and Disability services standards NZS 8134: 2021
- Human Rights Act 1993
- Health and Safety at Work Act 2015
- Health and Disability Commissioner Act 1994
- Health Practitioner Competency Assurance Act 2003
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998

Disclosure of forensic and/or criminal history for tāngata whaiora in vocational rehabilitation

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Tania Christie
Document Facilitator Title	Therapeutic Programme Coordinator, Puawai: Midland Regional Forensic Psychiatric Service
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions Service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
02	Joanne Parker	July 2015	Aligned to Integrated Care Pathway terminology; and provided specific information on documentation
03	Joanne Parker		Rename and align to clinical practice pathways
04	Tania Christie	August 2022	Functional assessment added. Rationale provided as to why tāngata whaiora are supported to obtain a history of criminal convictions. Changed to current Te Whatu Ora template.

Disclosure of forensic and/or criminal history for tāngata whaiora in vocational rehabilitation

Contents

Disclosure of forensic and/or criminal history for tāngata whaiora in vocational rehabilitation

1 Overview

1.1 Purpose

The procedure is aimed at providing a guideline for mental health professionals to support tāngata whaiora in making decisions about when disclosure of criminal history and / or forensic history may be justified, prior to vocational placements in the areas of employment, work experience and further education.

1.2 Scope

This procedure applies in the process of assisting tāngata whaiora into vocational placement opportunities. Mental Health Professionals have, in the past, supported tāngata whaiora with a forensic history / criminal history into vocational placements. There has been an informal process to screen tāngata whaiora to ensure the risks to the individual and the placement are minimised. This procedure aims to formalise the process to ensure all people involved are informed and follow best practice. This procedure must be acted on within the domains and to the expectations of the following policies:

- Health Information Privacy (Ref. 1976)

1.3 Patient / client group

Tāngata whaiora of the Mental Health and Addictions service.

1.4 Exceptions / contraindications

Nil.

1.5 Definitions and acronyms

Criminal and traffic conviction history	Historic record of criminal and traffic convictions which is held by the Ministry of Justice
Disclosure	The act of revealing or uncovering information. Providing information about previous criminal history
Forensic history	A person who has a history where charges have been laid but no conviction has been entered due to either not guilty on the grounds of insanity (NGRI) or not being fit to stand trial. In this case there is no record in the criminal history of these charges.
Mental health professional	All registered health professionals as noted in the Health Practitioners Competency Assurance Act 2003 and in addition social workers, psychotherapists, counsellors and cultural advisors.
Multidisciplinary team	Members from various disciplines who work together with tāngata whaiora and their whānau to determine goals, evaluate outcomes, and make recommendations to support tāngata whaiora care.
Placement supervisor	Person co-managing vocational placement who is a non-Te Whatu Ora - Waikato staff member e.g. Enrich +

Risk management	A systematic approach to the management of risk, staff and tāngata whaiora safety. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.
Special patient	A person who has been found not guilty on the grounds of insanity (NGRI) by the court. Those found NGRI or unfit to stand trial may become special patients. Reference to Mental Health (Compulsory Assessment & Treatment Act, 1992 and the Criminal Procedure (Mentally Impaired Persons) Amendment Act 2003 (CPMIP).
Victim notification process	Victim notification process offers victims of serious crime an opportunity to stay informed about the person who offended against them. (Reference to Mental Health (Compulsory Assessment & Treatment Act, 1992).
Vocational Rehabilitation	Is a process which enables tāngata whaiora with disabilities to overcome barriers to accessing, maintaining, or returning to employment, education or other meaningful occupation
Vocational rehabilitation team	Tāngata whaiora, mental health professional team members including: registered mental health professional and support staff.

2 Clinical management

2.1 Roles and responsibilities

All Staff
To support the decision making process through the multidisciplinary team.

Mental Health Professional Team
The clinical staff working with the tāngata whaiora in vocational rehabilitation will follow the procedure in their clinical practice.

Managers
Charge Nurse Manager, Associate Nurse Manager and/or Team Leader will provide management and leadership to support the clinical team working in vocational rehabilitation.

2.2 Competency required

Must be a registered mental health professional.

2.3 Equipment

Ministry of Justice – Request your own criminal conviction history

https://www.justice.govt.nz/criminal-records/get-your-own/

2.4 Procedure

1. Assessment – Recovery Planning

The tāngata whaiora has identified a goal to engage in vocational rehabilitation including: employment, work experience or further education. A meeting will be held with the tāngata whaiora, mental health professional, member of the multidisciplinary team and responsible clinician and/or case manager to collaborate on a vocational rehabilitation plan. The partnership with tāngata whaiora and the vocational rehabilitation team and multidisciplinary team need to be in agreement regarding the nature, extent and process of disclosure of criminal history and / or forensic history. While guidance can be given, disclosure of criminal convictions and health information is at the discretion of the tāngata whaiora. Whānau to be included in this process if the tāngata whaiora wishes for them to do so. Assessment will include but not limited to:

- Risk assessment
- Substance Use Assessment
- Workplace assessment
- Work skills assessment
- Functional Assessment

Following the assessment process the vocational rehabilitation team will engage with tāngata whaiora in developing the disclosure plan prior to recruitment process. The clinician will support the tāngata whaiora to be confident in their agreed disclosure plan and know how this process will occur during the recruitment phase and ongoing employment or engagement. The clinician will discuss the implications of non-disclosure with the tāngata whaiora. It is then up to the tāngata whaiora to make the decision as to whether they will disclose or not. This will not be a barrier to continued engagement in the vocational rehabilitation pathway but it may impact the timeliness and engagement in the recruitment phase.

During the process of recruitment into work, volunteer roles and education pathways the vocational rehabilitation team will collaborate with the employer or agency to meet the employer's employment processes and policies. This may include the expectation for all prospective employees to agree to a police check or drug screen depending on the organisation they are applying to.

2. Clinical Reasoning

The vocational rehabilitation team will take into account the nature of the offences and risk issues when matching the person with a suitable vocational placement. The vocational rehabilitation team with tāngata whaiora will agree on the information which needs to be disclosed to the employer at the vocational placement. The vocational team will support the tāngata whaiora in the process of disclosure.

3. Disclosure or non-disclosure of criminal history and / or forensic history

If the tāngata whaiora consents to agreed disclosure of criminal history and / or forensic history the vocational rehabilitation placement will proceed.

If the tāngata whaiora declines to give consent to agreed disclosure of criminal history and / or forensic history the vocational placement will not proceed imminently. A further meeting will be arranged with the vocational rehabilitation team to review the vocational rehabilitation plan with a focus toward preparation and readiness for employment and / or education.

In the case of those detained as 'Special Patients' a wider discussion will be held with the tāngata whaiora, the vocational rehabilitation team, multidisciplinary team and the DAMHS given their legal status. This team together will consult and agree on:

- The vocational rehabilitation pathway
- All legal responsibilities including informing the Ministry of Health re: leave status and any changes to leave plan as agreed by Responsible Clinician, DAMHS and multidisciplinary team for vocational rehabilitation
- Potential vocational placements
- Appropriate disclosure about legal status and the fact criminal offending led to the order being made
- Agreement on the appropriate detail of the actual offence and whether this may or may not be disclosed
- The intention of achieving safe, open and transparent communication between all parties will include full disclosure in most circumstances aiming to avoid surprises
- Leave status

In the case of those who are no longer special patients, the same process or similar process will apply as outlined above for those detained as 'Special Patients'.

4. Process of disclosure of criminal conviction history

If the tāngata whaiora gives consent to proceed with disclosure they should then be supported to obtain a history of criminal convictions so that they can take ownership of and manage the information accordingly. The information on the history can then be reviewed by the tāngata whaiora and their vocational rehabilitation team. If areas of concern are identified and additional clinical decisions are required then this information will be reviewed by the multidisciplinary team. A plan will be developed regarding what information needs to be shared for a vocational placement. The mental health professional with the tāngata whaiora will complete the request for criminal conviction history form in two ways:

1. Request for criminal conviction history – third party. This is provided to the employer for completion and sending to the Ministry of Justice
2. Request for criminal conviction history – individual. The tāngata whaiora with the mental health professional will send this form to the Ministry of Justice.

5. Communication of criminal history and / or forensic history

The tāngata whaiora has obtained their criminal history record and / or a decision has been made regarding what information to disclose. At this point the vocational rehabilitation will focus on developing effective communication skills specific to disclosure of criminal history and / or forensic history in preparation for vocational opportunities

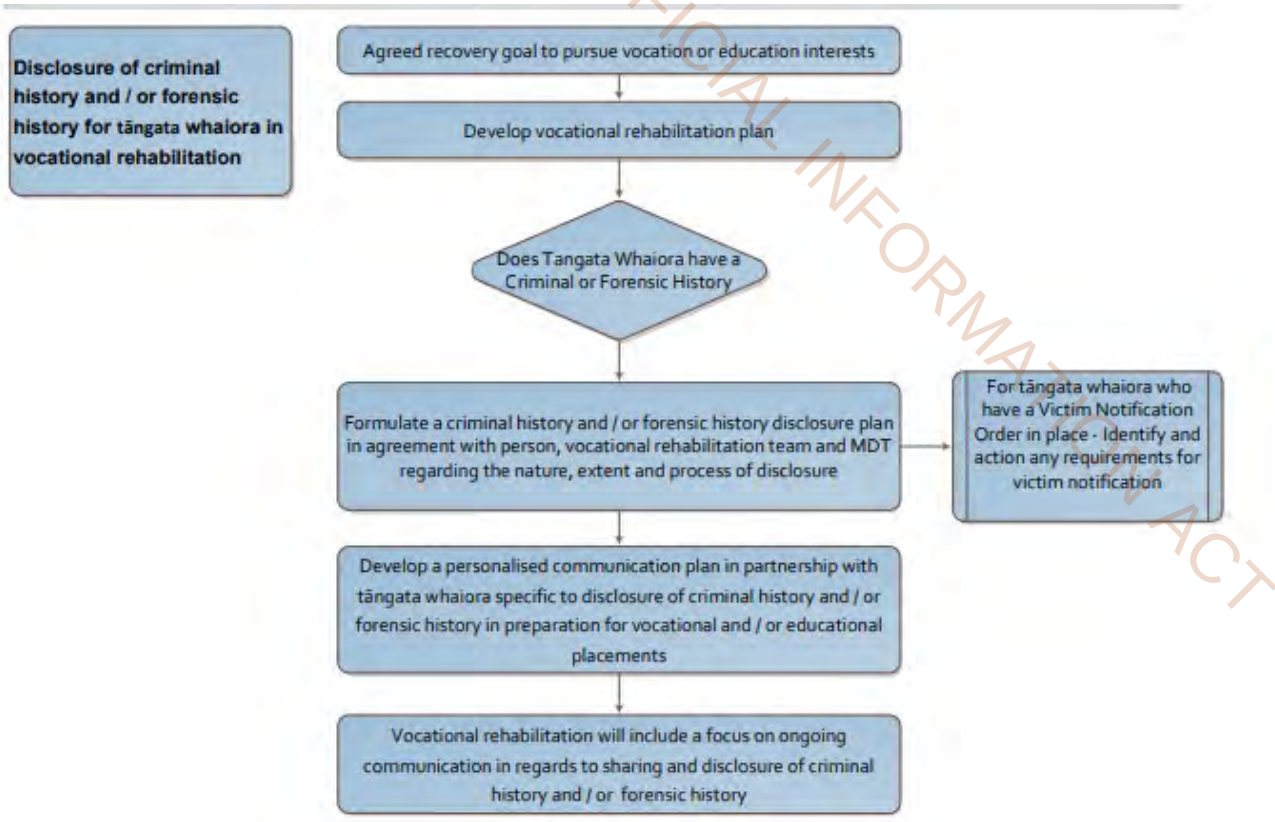
6. Vocational placement support specific to disclosure

On commencement of vocational placement from interview to employment the tāngata whaiora will be supported by the vocational rehabilitation team. This will include mentoring and coaching the tāngata whaiora with ongoing communication through the employment process specifically, disclosure of criminal and / or forensic history.

7. Victim notification

The victim notification process must be followed as per the Ministry of Health guidelines, prior to commencement of the vocational placement. This applies to tāngata whaiora who have special patient status and those with a victim notification order in place.

8. Process



3 Patient information

Nil.

4 Audit

4.1 Indicators

- Mental health professionals in the vocational rehabilitation teams understand their responsibilities and are able to articulate these. There is evidence that the tasks required are completed and documented in the clinical notes.

4.2 Tools

Monitoring and reporting by team leader.

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

- Privacy at Work – A guide to the Privacy Act for employers and employees - https://www.privacy.org.nz/assets/Files/Brochures-and-pamphlets-and-pubs/Privacyat-Work-2008.pdf
- Ministry of Justice, New Zealand Criminal Records (Clean Slate) Act 2004
- Waikato DHB Health Information Privacy policy

5.2 Bibliography

- NHS code of practice: Confidentiality
- NHS code of practice: Public disclosures
- Mental Health Foundation of New Zealand: Social Inclusion and exclusion, stigma and discrimination, and the experience of mental distress 2017
- Mental Health Foundation of New Zealand: What Works: Positive experiences in open employment of mental health service users 2015
- Mental Health Foundation of New Zealand: Return to Work
- Health Information Privacy Code 1994 https://www.privacy.org.nz/the-privacy-act-andcodes/codes-of-practice/health-information-privacy-code-1994/
- Privacy Act 1993 http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM297038.html
- Waikato DHB Policy – Health Information Privacy
- Criminal Record Checks https://www.employment.govt.nz/workplace-policies/tests-andchecks/criminal-record-checks/

- When the Clean Slate scheme applies https://www.justice.govt.nz/criminalrecords/clean-slate/
- Ministry of Justice, New Zealand Criminal Records (Clean Slate) Act 2004 http://www.legislation.govt.nz/act/public/2004/0036/49.0/DLM280840.html
- Get your own criminal record https://www.justice.govt.nz/criminal-records/get-your-own/
- Request criminal record by individual https://www.justice.govt.nz/assets/Documents/Forms/request-byindividual.pdf
- Special Patients and restricted patients: guidelines for regional forensic mental health services https://www.health.govt.nz/publication/special-patients-and-restricted-patientsguidelines-regional-forensic-mental-health-services
- Telling someone about your criminal record https://www.govt.nz/browse/law-crimeand-justice/disclosing-your-criminal-record/
- How do I get on the Victim Notification System? https://www.police.govt.nz/faq/how-do-i-get-on-the-victim-notification-system
- Victims Code - http://www.victimsinfo.govt.nz/support-and-services/victimsrights/victims-code-full-text-version/
- Victims' Rights Act 2002 Guidelines 2018 https://www.health.govt.nz/publication/victims-rights-act-2002-guidelines-2018

5.3 Associated Te Whatu Ora Documents

- Te Whatu Ora Waikato Health Information Privacy policy (Ref. 1976)

DUNDRUM Toolkit Use on the Recovery Pathway in Puawai

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Puawai: Midland Regional Forensic Services
Document Facilitator Name	Deborah Jennings
Document Facilitator Title	Clinical Nurse Specialist
Document Owner Name	Kylie Balzer
Document Owner Title	Operations Manager MHAS
Target Audience	Clinical staff Puawai
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes

DUNDRUM Toolkit Use on the Recovery Pathway in Puawai

Contents

DUNDRUM Toolkit Use on the Recovery Pathway in Puawai

1 Overview

1.1 Purpose

To ensure best practice in the use of the DUNDRUM toolkit to facilitate the tāngata whaiora rehabilitation pathway in Puawai forensic services.

1.2 Staff group

This guideline applies to all registered health professionals within the Puawai forensic service.

1.3 Patient / client group

All prisoners on the Puawai waitlist, and those prisoners who have been assessed as needing to be placed on the waitlist. Tāngata whaiora in inpatient Puawai forensic services who are defined as being on the Puawai rehabilitation pathway and suitable adult rehabilitation tāngata whaiora currently in the adult rehabilitation beds (ARB) in Puawai.

1.4 Exceptions / contraindications

Prisoners who are returning to prison after acute care.

Definitions and acronyms

ARB	Adult Rehabilitation Beds
DUNDRUM	Dangerousness Understanding ,Recovery and Urgency Manual
HCR-20-V3	Historical-Clinical-Risk management –Version 3
Longer term tāngata whaiora	Longer term tāngata whaiora – a mix of Forensic and Adult Rehabilitation Bed Patients (ARB)
Special Patients	Patients who are remanded to or detained in a hospital under specific legislative provision. *For further information see the Ministry of Health (2022) Special Patients and Restricted Patients. Guidelines for Regional Forensic Mental Health Services.*

2 Clinical management

2.1 Roles and responsibilities

Clinicians
All clinicians complete the DUNDRUM components 1-4 accurately and within the stated time frames.

Charge Nurse Managers
The Charge Nurse Managers are to ensure the DUNDRUM components are understood and used correctly as a clinical assessment and treatment tool by all clinicians within each team. Review any feedback so quality improvements can be initiated in consultation with the DUNDRUM support team.

2.2 Competency required

All clinical staff to attend education sessions on the DUNDRUM toolkit.

2.3 Equipment

- Scoring sheet and manual for DUNDRUM 1: Triage Security Items
- Scoring sheet and manual for DUNDRUM 2: Triage Urgency Items
- Electronic clinical record for DUNDRUM 3: Programme completion Items/ Health Care Recovery Plan (HCRP) and DUNDRUM manual
- Electronic clinical record for DUNDRUM 4: Recovery items / HCRP and DUNDRUM manual.
- Electronic clinical records for DUNDRUM Puawai clinical review.

2.4 Guideline

2.4.1 DUNDRUM 1: Triage Security Items

Score the 11 items on the grid provided using the DUNDRUM manual to ascertain who should be on the prison waitlist for admission to Puawai inpatient services. Triage items are all predicated on there being an established mental disorder present (through a preadmission assessment).

Those rated mostly ‘4’ are likely to require high therapeutic security.

Those rated mostly ‘3’ will require medium secure therapeutic security.

Those mostly rated ‘2’ would be best treated in acute low security (adult services)

Those mostly rated ‘1’ will be cared for in an open inpatient setting

Those mostly rated ‘0” may be cared for in community settings and prison in-reach teams.

This doesn’t preclude admission to forensic inpatient services if appropriate.

2.4.2 DUNDRUM 2: Triage Urgency Items

This is used to provide a structure for deciding who on the waitlist is the most urgent for admission, in practice though legal obligations can over-rule clinical priority. As for all professional judgement tools, the decision makers are not bound by the results of the assessments (individual context may influence the urgency for admission).

Score the 6 urgency items on the grid provided using the DUNDRUM manual. Ensure the correct scoring grid is used for **Court/Remand** prisoners and **Sentenced** prisoners. The higher the score the greater the urgency.

All ratings are based on the accompanying manual.

Triage Security and Urgency items are to be completed prior to placing an individual on the waitlist and these documents are uploaded into documents.

Urgency items are to be revised weekly at the prison team clinical meetings until admitted or taken off the waitlist. The weekly scoring is to be added to the prison waitlist by each tāngata whaiora name.

2.4.3 DUNDRUM 3: Programme Completion Items

There are two goals of the treatment programmes:

1. To reduce the probability (risk) of future harmful behaviour.
2. To reduce the seriousness of harm should a similar scenario recur that has previously led to serious harm.

The programme completion items are called the 7 pillars of care and treatment.

1: Physical Health

2: Mental Health

3: Drugs and Alcohol Recovery

4: Problem Behaviours (offence related behaviour)

5 Self Care and Activities of Daily Living

6: Education, Occupation and Creativity

7: Family and Intimate Relationships

8: Cultural (Whilst this isn't scored as the other 7 items, it is seen as being integral to many tāngata whaiora recovery)

The programme completion items are part of the comprehensive Health Care Recovery Plan (HCRP). This is scored and the plan developed by the clinical team. The initial scoring using the electronic DUNDRUM manual and the HCRP development is done within 6 weeks and then updated 6 monthly or on movement.

To assist in the development of the HCRP a functional assessment may be required. The HRC20-V3 is a requirement including 6 monthly updates.

Those mostly rated '4' are unlikely to be ready to move to a lower security setting.

Those mostly rated '3' may be ready to move to a lower security setting.

Those mostly rated '2" may be ready to move to a low security setting.

Those mostly rated '1' maybe ready to move to an open or community placement.

When the initial HCRP is developed it may be that the tāngata whaiora is still too unwell to attend identified groups. In the HCRP it is possible to identify dates and wards when the interventions should take place. The initial plan is to identify the treatment needs and if possible to start treatment.

2.4.4 DUNDRUM 4: Recovery Items

There are 7 recovery items that are scored.

R1: Stability

R2: Insight

R3: Therapeutic rapport

R4: Leave

R5: Dynamic Risk Items

R6: Victim Sensitivity Items

R7: Hope

The Recovery items sit below the programme completion items electronically in the HCRP and are to be scored concurrently with the DUNDRUM 3 programme completion items 6 weekly, 6 monthly or on movement.

2.4.5 DUNDRUM Clinical Review

The electronic Puawai DUNDRUM Clinical review is formatted to reflect the pillars of care in the programme completion items.

The closed groups in the therapeutic programme and ward based programmes will reflect the pillars of care. Attendance and engagement will be documented in the progress notes by clinical staff facilitating these groups.

The attendance and engagement information will be transcribed into the Puawai DUNDRUM clinical review each week/fortnightly or monthly depending on the ward, so progress within the 8 pillars of care and treatment can be assessed.

After a 6 month review and updated scoring a new HCRP will be developed with any changes in goals identified by the clinical team.

2.4.6 DUNDRUM General Information

The tāngata whaiora will also be expected to complete a 6 monthly self-assessment on DUNDRUM 3-programme completion items and DUNDRUM 4- recovery items.

All referral movements will need to be presented to the Pathway Panel. This will be made up of 1x representatives from the three streams – Acute, Rehabilitation and Tamahere, Programmes Clinical Lead, Service User Representative, Clinical Director (or delegate) and Puawai Clinical Nurse Specialist.

Documentation would include an updated HCR20-V3, current risk, current DUNDRUM scores, HCRP, latest clinical review and a brief summary of the tāngata whaiora history and progress to date.

This would not preclude wards from presenting longer term tāngata whaiora if they believe a move to a less secure ward is appropriate.

Under the new DUNDRUM format tāngata whaiora in the rehabilitation wards would need to be reviewed monthly. This will assist in the collation of information about group participation for tāngata whaiora being cared for under DUNDRUM.

Puawai Streams of tāngata whaiora

In Puawai 3 streams of tāngata whaiora have been identified:

1. Acute Care pathway –returning to prison after treatment.
2. Rehabilitation Care pathway – Special patients, Section 30 patients and Adult Rehabilitation Bed (ARB) patients- Care under DUNDRUM 3 and 4.
3. Longer term tāngata whaiora – (long term –a mix of forensic and ARB patients)

Care under DUNDRUM 3 and 4. For some longer term tāngata whaiora group participation is minimal. A plan of care can still be developed under DUNDRUM 3 but only scoring on the Recovery items in DUNDRUM 4 if necessary.

2.4.7 Documentation

Acute Care pathway: Puawai Clinical review / Recovery plan-(Tāngata Whaiora Inpatient).Replacing the current recovery plan used.

Rehabilitation Care pathway: DUNDRUM 3 and 4 – Puawai DUNDRUM comprehensive HCRP / DUNDRUM clinical review.

Longer term tāngata whaiora: DUNDRUM 3 and 4 – Puawai DUNDRUM comprehensive HCRP with scoring in DUNDRUM 4 only if necessary. DUNDRUM clinical review.

3 Patient Information

Each tāngata whaiora participating in the DUNDRUM programme will receive a group programme handbook. This is their own record of progress and visually gives them some understanding of the work they need to do to be ready for discharge to live their “good life” The handbook should accompany each tāngata whaiora as they move through their rehabilitation pathway.

4 Audit

4.1 Indicators

DUNDRUM 1-4 is used in accordance with this guideline.

4.2 Tools

Clinical audit of files using the DUNDRUM toolkit.

5 Evidence base

5.1 References

- Kennedy, H.G., O'Neill, C., Flynn, G., Gill, P, and Davoren, M. (2016). The DUNDRUM Toolkit. DANGEROUSNESS UNDERSTANDING, RECOVERY and URGENCY MANUAL (THE DUNDRUM QUARTET). Structured Professional Judgement Instruments for Admission Triage, Urgency, Treatment Completion and Recovery Assessments.

5.2 Associated Te Whatu Ora Waikato Documents

- Admission, Discharge and Transfer policy (Ref. 1848)
- Clinical Records Management policy (Ref. 0182)
- Informed Consent policy (Ref. 1969)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (Ref. 5241)

5.3 External standards

- Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)

Duress alarm use and management inpatient Mental Health and Addictions

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
02	Kylie Balzer Nicola Barlow	June 2018	Inclusion of duress use and management in OPR1 Inclusion of individual duress provision to individual staff in Puna Maatai and Puna Awhi-rua
		January 2019	Updating of duress information for all areas

Duress alarm use and management inpatient Mental Health and Addictions

Contents

Duress alarm use and management inpatient Mental Health and Addictions

1. Overview

1.1 Purpose

The purpose of this procedure is to ensure that all staff are able to use the duress system effectively to maintain safety of service users and staff.

1.2 Scope

This procedure applies to all staff within the inpatient Mental Health and Addictions service

1.3 Patient / client group

Mental Health and Addictions staff

1.4 Exceptions / contraindications

Nil exceptions

1.5 Definitions

HRBC	Henry Rongomau Bennett Centre

2. Clinical Management

2.1 Roles and Responsibilities

All Staff

All staff are responsible for checking duress alarms when allocated and the care of duress alarms

Managers

Managers are responsible for ensuring duress alarms are available in clinical areas

2.2 Competency required

All mental health and addictions staff providing direct client care, or visiting client care areas are required to be proficient in the use of the duress system

2.3 Equipment

Duress alarms
Radio transmitter – inpatient HRBC
Emergency response team

2.4 Procedure

Henry Rongomau Bennett Centre

Checking of Duress Alarm

Black duress alarms: Checking a duress alarm requires a single press of the black button – the red light flash indicates that the alarm is connecting to the network.

A periodic double beep indicates a low battery which requires immediate attention and a need to change the batteries. All inpatient ward areas are required to have a stock of AAA batteries.

White duress alarms: Checking network connection – short press of the grey button 1 flash = off network, 2 flashes = on network.

To turn on the duress alarm press the grey button for up to 3 seconds and it will beep. To turn off press the grey button for up to 3 seconds and it will beep.

The white duress alarms are charged and if the alarm is still charging there will be a flash every 3 seconds, when fully charged there will be 2 flashes every 3 seconds. When the battery is low the duress will vibrate and bleep.

If being issued a duress by Security staff the security staff member will be responsible for checking the duress prior to issue.

All staff are required to check that their duress is operational at the beginning of each shift.

Duress activation – Henry Rongomau Bennett Centre

In the event of an emergency requiring a response team within the Henry Rongomau Bennett centre (HRBC), press the red button once. This will alert the HRBC Emergency Response Team, the HRBC coordinator and security via pagers and ward enunciators.

All wards will send at least one response person unless that ward would be left unsafe as a result.

Once HRBC security receive pager notification they are required to open the appropriate forensic secure doors for easy access. This will require temporary over-riding of the air lock doors on both levels and enable staff movement within levels.

Duress activation – OPR1

In the event of an emergency requiring a response from Security the staff member presses the red button on the duress alarm once. This will provide an alert to the Waikato Hospital Security service.

OPR1 also has emergency alarms situated on the wall in the interview rooms.

Security will respond and provide assistance to staff in the ward. Security should also notify the HRBC coordinator.

Emergency call buttons situated on the bed panels in the High Dependency area of OPR1 and ensuites of bedrooms within the main ward area of OPR1 will alert an emergency within the ward area. The shift leader will be required to respond and alert security via the duress alarm system as required.

The ACNM / delegate in OPR1 will check that their duress is operating each day. To do this they should call security at the Henry Rongomau Bennett Centre and advise that they are performing a duress test, and then undertake a test by activating a duress point on the ward.

Duress activation – Puna Whiti

Puna Whiti have two wall duress alarms – one situated in the office area, and one on the wall outside the kitchen. These duress alarms provide an alert that security assistance is required in this area.

Duress storage

The care and storage of duress alarms is important as these are a key safety piece of equipment for all staff. Duress alarms should remain in the clinical areas / storage areas and not leave the unit with the exception of responding to emergency situations.

Adult inpatient wards:

At the completion of each shift staff are to return their duress alarms to the designated duress storage area in adult mental health service wards.

OPR1:

The three duress alarms allocated within OPR1 are held by the shift lead, and two designated staff members. These alarms are to be handed over to oncoming staff as part of the handover process.

Puna Maatai and Puna Awhi-rua

All permanent staff in Puna Maatai and Puna Awhi-rua are allocated individual duress alarms. Staff will access their duress alarm from the duress cupboard with their internal swipe card. Staff are responsible for ensuring that the alarm is in working order before entering the wards. Responsibilities in relation to individually allocated duress alarms are as outlined in the document in Appendix A.

Non-permanent staff to these areas will be allocated a duress alarm from security booth 2. These staff will be required to sign the alarm out, and back in on exiting the unit.

Puna Taunaki

In Puna Taunaki the duress is signed in and out on the clipboard next to the duress cupboard on each shift stating the duress number which is engraved on the casing. At the completion of each shift staff are to return their duress to the duress storage area.

Puna Poipoi

Puna Poipoi staff will sign their duress in and out from security each shift stating the duress number which is engraved on the casing.

Non-functional duress

In the event that a duress alarm is not working, this is to be reported to the respective charge nurse manager immediately. A replacement alarm will be supplied during the period the alarm is out of action.

False Alarm

In the event of a false alarm in HRBC the ward will use their Radio Transmitter to alert security and the other wards that it is a false alarm.

In the event of a false alarm in OPR1 the shift leader will contact Security via telephone.

3. Audit Indicators

3.1 Indicators

A timely response to psychiatric emergency incidents within Mental Health inpatient wards

3.2 Tools

Review of DATIX incident reports related to psychiatric emergency responses

4. Evidence Base

Associated Documents

Eko – Tek fob quick instructions for HRBC duress alarms

HRBC duress battery procedure – security manual

Waikato DHB Security Policy (0120)

Appendix A

Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

The Henry Rongomau Bennett Centre
Private Bag 3200
Hamilton 3240

All enquiries
Tel: 07 8398987
Personal Equipment – XXXXX

Name:	Unit:
Designation:	Date:
Alarm#:	

The mental health and addictions service is committed to the health and safety of staff, service users and visitors. In order to maintain the safety and well-being of all the above items are being issued to you.

The above item has been issued to you personally and you are responsible for it. The replacement cost of a personal alarm is approximately $450.00. In order to maintain and ensure the safety of both yourself and your colleagues it is paramount that you follow the issuing/allocation process as per below. Your personal alarm is only allocated to you and is not for use by any other staff member. The borrowing of your duress alarm is strictly forbidden. Duress alarms for students and visitors will be managed via the security booth.

Should your personal alarm require servicing or repair the cost will be met by the Service. Flat batteries are indicated by a 'beep' every 20-30 seconds, or testing as per your unit protocol. If you find it is not functioning return the alarm to your respective charge nurse manager for repair and a replacement alarm will be issued. You are liable for 50% of the replacement cost ($225), if you lose your duress alarm.

Staff will self-issue the above items with a unique number via the access controlled and camera monitored charging station cupboards with the expectation that staff return these items for charging at the conclusion of their shifts. Your duress is numbered both externally and via internal programming. It sits in a charging station with your name clearly visible. Regular audits will identify whether your duress alarm is where it should be (On your person because you are on duty or charging, because you are not at work). The secure storage cupboards have camera footage and access control, so should there be any discrepancies around allocation/returning of the items this can be referred to.

All equipment supplied to staff remains the property of the Henry Bennett Centre and should be returned when resigning from the service.

I have read the above and agree to meet the conditions specified.

Signature:_____

Home Address:_____

Telephone:_____

Electroconvulsive Therapy

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions
Document Facilitator Name	Matthew Jenkins
Document Facilitator Title	Specialist
Document Owner Name	Rees Tapsell
Document Owner Title	Director of Clinical Services
Target Audience	Staff involved in the care of patients having ECT
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Te Whatu Ora Health New Zealand assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
07	Matthew Jenkins	August 2019	Changed to Guideline template Inclusion of online referral Inclusion of maximum of one outpatient per day Inclusion of unilateral standard for ECT Changes made based on consultation process
08	Teresa Carroll	August 2023	Changed to Te Whatu Ora template Availability changed to be in line with service delivery Changes to preparation for ECT Wait time post PARS brought in line with other outpatient clinics Inclusion of requirement for a second opinion if needing a 3rd course of treatment Outpatient management updated

Electroconvulsive Therapy

Contents

Electroconvulsive Therapy

1 Overview

1.1 Purpose

This guideline outlines how Electroconvulsive Therapy (ECT) is to be delivered in a safe and professional manner by clinical staff in the Mental Health and Addictions service.

1.2 Staff group

This guideline should be used by

- prescribers of ECT
- treating medical staff
- anaesthetic technicians
- registered nurses

1.3 Patient / client group

ECT is prescribed by senior medical staff (psychiatrists, MOSSs and authorised registrars), and is available to all patients within the Te Whatu Ora Waikato region for the treatment of appropriate psychiatric disorders. Clinical indications for ECT include: depressive disorders, bipolar disorder, treatment-resistant schizophrenia, schizoaffective disorder, catatonia and neuroleptic malignant syndrome. ECT can be considered a first-line option when rapid clinical improvement is required, for example, when there is medical compromise due to poor oral intake, high suicide risk or previous positive response to ECT.

1.4 Exceptions / contraindications

ECT is not provided to tāngata whaiora (henceforth described as patients) who are under the age of 18 except in exceptional circumstances and following full consultation with all key stakeholders including whānau. ECT may be withheld at the discretion of the ECT provider or ECT anaesthetist. ECT is not provided on weekends or public holidays.

ECT is not a treatment modality for those exclusively with personality disorders or where personality disorders are the predominating clinical concern at the time of referral. It is accepted that personality disorders might be a co-morbid diagnosis when a primary indicator for ECT is well established

1.5 Definitions and acronyms

Responsible clinician	The clinician in charge of the treatment of a patient subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992.
Second opinion	The opinion supplied by an approved Psychiatrist not being the patient's Responsible Clinician, regarding treatment of a patient with ECT under Section 60(b) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
MOSS	Medical Officer Special Scale

2 Clinical management

2.1 Roles and responsibilities

All clinicians will perform their duties in line with their scope of practice and specific role within the ECT team:

ECT Clinical Nurse Specialist (CNS)

- To coordinate the ECT service
- To be a resource for advice and support for clinicians

PACU assigned nurse

- To recover the patient from anaesthesia until PARS (post anaesthetic recovery score) is met. To oversee and provide support for the escorting registered nurses

ECT designated registered nurse/ward assigned registered nurses

- Nursing cares pre and post treatment as per the ECT nursing procedure
- Completing pre and post ECT documentation
- Following direction from ECT CNS, PACU registered nurse, anaesthetist or treating Dr

ECT Anaesthetic Technician

- Assisting the ECT anaesthetist(s) in preparing the patient for general anaesthesia
- Assisting with airway management during the treatment session

Charge Nurse Manager

- The line manager for the ECT team attends operational multidisciplinary ECT team meetings and escalates any issues

Observers

- Any staff member or trainee wishing to observe a treatment must coordinate this with the ECT Clinical Nurse Specialist or ECT nurse prior to the day of treatment, and must obtain the patient's consent, preferably the day before treatment.

2.2 Competency required

All responsible clinicians will have the knowledge they require to refer to / prescribe ECT.

All ECT providers will have attended a specialised ECT service training prior to delivering treatments. New ECT providers will undergo a period of supervision prior to independently providing ECT treatments. ECT providers will attend a specialised ECT training at least every five years.

All anaesthetic and post anaesthetic care staff will have completed the appropriate training in line with their scope of practice. The ECT clinical lead anaesthetist will have attended specialised ECT training and maintain currency in general anaesthesia in relation to ECT.

All registered nurses will have completed the appropriate level of training in relation to their specific role in ECT delivery and resuscitation training as per the Te Whatu Ora Waikato Resuscitation policy (Ref. 1970).

2.3 Equipment

- ECT machine, back up ECT machine, electrodes, paddles and conduction gel / liquid
- Computer/monitor with Genie (software) and Clinical Workstation (software)
- General anaesthesia medications, monitoring system and equipment
- Emergency equipment
- Room and bed for the delivery of ECT
- Room, beds and equipment for post anaesthetic recovery and nursing monitoring
- The ECT CNS or ECT designated nurse will ensure a portable duress alarm and a Radio Transmitter (RT) is available in the ECT suite to summon immediate assistance in the event of an emergency.

ECT documents available electronically and in hard copy format

1. **ECT Information Booklet** (G202MHP) for patients and family/whānau
2. **Anaesthetic & PACU record + anaesthesia consent forms** (HP247 –W140)
3. **Electroconvulsive Therapy (ECT) electronic referral on the clinical workstation**
4. **Electroconvulsive Therapy (ECT) Consent Form** (T1565MHF)
5. **The Mini-Ace (Mini-Addenbrooke's Cognitive Examination)**
6. **Montgomery & Asberg Depression Rating Scale (MADRS)** (A1641MHF)
7. **Compulsory Treatment Section 60(b) Mental Health Act 1992** (T1565MHF)
8. **ECT Treatment Record** (T1564MHF)
9. **ECT pre/post Treatment Checklist** (T1566MHF)
10. **PACU Observation Chart** (A1717HWF)

2.4 Guideline

Availability of ECT treatment

- ECT will be administered in the ECT suite, Level 2 Henry Rongomau Bennett Centre, from 0830hrs- 1230hrs on a Tuesday and Friday. Treatment may be administered in the general theatres for medical reasons.
- A maximum of ten (10) patients will receive treatment each morning. In exceptional circumstances additional patients may be negotiated with the PACU and Anaesthetic Departments, and treating psychiatrist. Alternatively an additional treating day may be negotiated.
- Bookings and cancellations of patients will be coordinated through the ECT CNS
- Each patient shall have an assigned registered nurse to escort and recover
- Treatment will not be available on weekends or public holidays unless in exceptional circumstances when special arrangements must be made with anaesthetists and the post anaesthetic care unit (PACU). Where a treating day falls on a public holiday, the list may be moved to the previous or following day, as negotiated with the Anaesthetic department and PACU in advance.

- The standard for ECT is Bifrontal delivery. Bitemporal and unilateral delivery is available if there is clear rationale provided.
- Although it is standard practice to administer two treatments per week, there are evidence based criteria to administer three under certain conditions albeit short term, before reverting back to twice per week.

Clinical responsibility

- The responsibility for prescribing ECT and education of the patient and whānau lies with the Psychiatrist responsible for the patient's care. Every patient who is to have ECT shall receive written information about ECT and the opportunity to discuss its content.
- Patients must have a documented psychiatric examination by the prescribing doctor (or delegate) prior to commencing a course of ECT
- Review / triage of all cases by the ECT CNS in the first instance, +/- involvement of the ECT MDT and ECT Clinical lead if determined by the ECT CNS
- The Responsible Clinician shall ensure that when a 'second opinion' is required for patients subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992, section 60(b), it is documented in the clinical record and on the second opinion form (T1565MHF) A second opinion is obligatory when a patient is said to require more than 2 courses of 12 treatments and/or at the request of the ECT service.
- A summary of discussion with whānau must be recorded on section 60(b) document
- Wherever possible the second opinion psychiatrist should be a member of the ECT service; the second opinion psychiatrist should not be a member of the same treating team as the patient.
- Informed, written consent must be obtained from the patient by the treating team (refer Te Whatu Ora Waikato Informed Consent policy (Ref. 1969)). This is compulsory for any patients who are not been treated under the Mental Health Act.
- No more than two (2) treatments should be prescribed at a time and the patient should have a clinical review at least after every second treatment unless receiving maintenance ECT. (refer information on maintenance ECT). Treatment reviews should include the relevant rating scales.
- A course of ECT must be booked through the online referral process
- The ECT CNS or designated ECT nurse will arrange an appointment for patients to be assessed for anaesthesia
- The ECT CNS or designated ECT nurse will book the first and subsequent treatments on the iPM system no later than midday on the day before treatment.

Medical assessment and work up

- The appropriate screening tools (as per online referral) must be completed as part of the medical assessment process and should be completed at appropriate intervals throughout treatment
- Routine haematology must include: full blood count, urea and electrolytes and others as indicated. These should be performed within five (5) days prior to first treatment. An ECG must have been performed in the previous two weeks.
- A chest x-ray should be performed if indicated
- All inpatients about to undergo a course of ECT will receive an anaesthetic assessment organised with the ECT Anaesthetist by the ECT CNS– usually following the treatment list. Urgent assessments outside these times are arranged with the duty anaesthetist, by the treating team.
- The anaesthetist will complete an Anaesthetic Assessment v2 CWS electronic form and obtain patient consent to anaesthesia or follow processes in the Te Whatu Ora Waikato Informed Consent policy (Ref. 1969) if the patient is not competent to consent
- Consultations with other specialties, for example, cardiology regarding pacemaker, will be arranged by the treating team as indicated
- Before the first ECT treatment for a woman who is pregnant, there must be consultation between the treating team, ECT CNS and the neonatal service to ensure monitoring of the foetus before and after each treatment, and to seek other advice as appropriate.
- The doctor prescribing ECT shall review the patient's medications prior to first treatment to ensure that anticonvulsant medications are rationalised. If the patient is on lithium then a clear statement of the decision to either stop or continue with this medication should be made. Aside from anticonvulsants and Lithium, benzodiazepines should also be discontinued; or as a minimum, switched to short-acting variants with doses withheld from 12 hours before ECT. Non-benzodiazepine sedatives should also be discontinued where possible.
- Other medications might need to be rationalised and this can be discussed with the ECT CNS/ECT Clinical Lead if there are queries.

Other consultations

- A cultural consultation should be requested by the treating team for any Māori patient being considered for, or prescribed ECT
- An interpreter will be provided if requested or required
- A Ministry of Health video explaining ECT is available on request and patients and whānau will be informed

Documentation

- All documents shall have a patient label attached as per TE Whatu Ora Clinical Record Policy (0182)
- All requests for a course of ECT shall be signed by a consultant psychiatrist, MOSS or authorised psychiatric registrar
- Patient consent must be gained and documented and the required form signed by the patient unless a second opinion under the Mental Health Act is required (T1565MHF).
- This consent can be witnessed by a psychiatrist, MOSS or authorised psychiatric registrar.
- Name, address and phone number of support person who will be staying with an outpatient for twenty-four hours once discharged after treatment, must be noted in the clinical record
- All documentation will be available to the anaesthetist and treating psychiatrist / registrar prior to each treatment
- All necessary documentation should be available to be checked by the ECT nurse on the day prior to the first treatment.
- Treatment and recovery to be documented sequentially in the patient's ECT record held in the clinical record (T1564MHF), and in the progress notes, including rationale for postponed or abandoned treatments
- The ECT CNS or designated ECT registered nurse will ensure patients receiving outpatient ECT are given the written carer information sheet, and the outpatient information sheet which will contain emergency contact names and phone numbers in case of post anaesthetic complications

Preparation for ECT

- The ECT CNS or ECT designated nurse will contact the relevant ward CNMs / ACNMs up to the day prior to treatment to confirm details of where and when to attend
- Patients shall be required to fast eight (8) hours prior to ECT treatment but can drink small amounts of clear fluids up to 2 hours before treatment
- Oral medications are given or withheld prior to treatment as directed by the anaesthetist / anaesthetic review and specified by the responsible clinician
- Each patient will have an escorting nurse who will follow the ECT nursing process
- The anaesthetist needs to be informed of any specific problem or hazard by the medical and / or nursing staff prior to induction
- Whānau may support the patient into the ECT treatment area, as negotiated with the wider ECT treating team, but will leave before the treatment commences and can wait in the waiting room.

Acute course ECT treatment sessions

- Acute courses of ECT will include treatment sessions scheduled twice weekly, unless by other arrangement.
- Six to twelve ECT treatments are a standard course, however clinical response determines the total number of treatments required. Treatment could be stopped at any stage if indicated for medical or psychological reasons or by the patient / whānau / medical teams.
- The ECT CNS leads a team safety meeting prior to the commencement of ECT treatments. The safety meeting will include introductions of all staff members and observers, discussion of relevant medical or safety concerns for each patient, management plans for identified issues, ECT electrode placement and ECT treatment number.
- The ECT provider(s) determine the treatment dose for each patient based on the dose titration protocol, electrode placement, stimulus parameters, quality of the seizure produced and response to treatment and in keeping with local, national and international best practices.

ECT – outpatient

- Outpatient ECT will be available for patients as clinically indicated
- The consent, physical examination and routine investigations will be the responsibility of the responsible clinician supervising outpatient treatment
- Patients must arrive at the ECT suite at the proposed time as advised by the ECT CNS or ECT designated nurse. An outpatient must have a relative, friend or responsible adult stay with them for twenty-four (24) hours post treatment.
- An ECT CNS or designated ECT nurse will complete the pre ECT checklist
- The ECT CNS or designated ECT nurse will escort the patient to ECT. A registered nurse with post anaesthetic care unit experience will be responsible for recovering the patient from anaesthesia after which the ECT CNS or designated nurse will continue monitoring the patient until s/he is fit to be discharged. The nurse will record observations in the patient's clinical record following each treatment.
- During an acute course of ECT the patient should be reviewed on a weekly basis by the consultant or delegate prescribing the ECT, and no more than two (2) treatments should be prescribed at any one time
- The ECT CNS or designated ECT nurse will ensure all outpatients receiving ECT are given an appointment with the date of their next treatment. Written outpatient ECT and carer's information sheets are given to the patient and carer at the start of a course of treatment. In case of post anaesthetic complications emergency contact phone numbers and names are identified in the written information provided.
- Outpatients, and inpatients who may be going on leave or who are discharged following that day's ECT, are to be told not to drive or operate machinery or electrical equipment for twenty-four (24) hours after treatment because the effects of

anaesthetics and / or drugs administered, and this is to be documented in the clinical record.

ECT – anaesthetic, stimulus and recovery

- Anaesthetic and muscle relaxant will be administered according to the relevant Australian and New Zealand College of Anaesthetists Guidelines
- ECT will only be administered either by a psychiatrist with appropriate training and experience, a registrar under the direct supervision of such a consultant or a registrar who has satisfactorily completed training as per RANZCP recommendations
- In exceptional circumstances, the patient may need to be admitted medically.
- ECT stimulation, re-stimulation and seizure termination protocol should be followed. A PDF copy of the EEG will be uploaded to clinical documents.
- Any adverse events occurring during treatment or during recovery will be managed according to the Royal Australian and Royal New Zealand College of Anaesthetists Guidelines. If the anaesthetist is no longer present it may be necessary to call the crash team or the anaesthetic emergency team on 99777.

Maintenance ECT

- Some patients may require maintenance ECT. This would normally vary between weekly and four (4) weekly. The patient should be reviewed at least every three (3) months, and have full blood count, urea, electrolytes and ECG at least every six (6) months or earlier if indicated. Re-consent from the patient should be obtained every six (6) months, or when the number of ECTs consented has expired, should this occur before six months has elapsed.

2.5 After care

- Post anaesthetic care unit procedures will be followed
- Patient will be offered a drink and light snack
- In-patients are returned to the ward by their assigned registered nurse using a wheelchair
- The responsible ward nurse will monitor patient for post ECT confusion or other medical complications in accordance with the Post Anaesthetic Nursing Responsibilities in Electroconvulsive Therapy (ECT) Suite procedure (Ref. 2506)
- In-patients must remain on the ward or other suitable recovery area for at least one hour post meeting PARS following ECT / anaesthesia. If a patient needs to leave the ward during this time a nurse escort must be provided.
- An in- patient requesting to leave the ward later than one hour post PARS but with 24 hours of ECT / anaesthetic must be accompanied by a responsible adult.

- Out- patients must remain in the ECT suite for at least one hour post meeting PARS following ECT / anaesthesia.
- The ECT CNS or ECT designated nurse will monitor the out-patient for post ECT confusion or other medical complications in accordance with the Post Anaesthetic Nursing Responsibilities in Electroconvulsive Therapy (ECT) Suite procedure (Ref. 2506)
- Out-patients should have another responsible adult at home with them for twenty four (24) hours post ECT, in case of complications, and be reminded not to drive or operate machinery
- Any withheld regular morning medication is to be given on return to the ward, or prior to going home if an outpatient (Refer to Te Whatu Ora Waikato Medicines Management policy (Ref. 0138)). Medications and valuables will be returned to the outpatient.
- The patient's responsible clinician or delegate must monitor progress weekly or after two ECTs during an acute course and change treatment requirements as necessary.

3 Patient information

- ECT Information Booklet (92024MHP)
- Review of Ministry of Health ECT video by patient / whānau

4 Audit

4.1 Indicators

- Clinical rating scales will be used routinely before, during and post-ECT treatment course
- There will not be unexpected adverse medical events attributable to ECT
- ECT referral documentation is accurate and complete
- Data from annual patient satisfaction surveys
- Staff education and training session feedback/surveys

4.2 Tools

- ECT Audit tool
- Patient satisfaction survey
- ECT training feedback documentation
- Incident management and Complaints systems

5 Evidence base

5.1 Bibliography / References

- Royal College of Psychiatrists Guidelines Position Statement 74 Electroconvulsive Therapy (ECT), August 2013
- The Royal Australian and New Zealand College of Psychiatrists Professional Practice Guideline Electroconvulsive Therapy (ECT) Draft 13.8 – September 2017
- Royal College of Psychiatrists ECT Accreditation Service (ECTASD) Standards for the administration of ECT Fourteenth edition revised: January 2019
- Royal Australian and New Zealand College of Psychiatrists Guidelines 1999
- American Psychiatric Association ECT Task Force recommendations 2001
- New Zealand Ministry of Health ECT Audit Report 2004
- PARS (Post-Anaesthetic Recovery Score) to aid discharge Procedure (Ref. 0176)

5.2 Associated Te Whatu Ora Waikato Documents

- ECT Information Booklet (92024MHP)
- ECT Checklist (for doctors and nurses) 92302MHF
- Anaesthetic & PACU record + anaesthesia consent forms (HP247 –W140)
- Electroconvulsive Therapy (ECT) Assessment Form (T1009MHF)
- Electroconvulsive Therapy (ECT) Consent Form (T1565MHF)
- Compulsory Treatment Section 60(b) Mental Health Act 1992 T1012 MH
- ECT Treatment Record (T1564MHF)
- ECT pre/post Treatment Checklist (T1566MHF)
- Observation Chart (A17117HWF)
- Clinical Records Management policy (Ref. 0182)
- Informed Consent policy (Ref. 1969)
- Interpreters and Translation policy (Ref. 0137)
- Medicines Management policy (Ref. 0138)
- Clinical Handover- Mental Health, Inpatient Wards procedure (Ref. 0451)
- Mental Health and Addictions Family / Whānau Inclusive Practice guideline (Ref. 5795)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others (Ref. 5241)
- Mental Health and Addictions Use of Personal Restraint in Mental Health and Addictions Inpatient Setting procedure (Ref. 1865)
- PACU Post Anaesthetic Nursing Responsibilities in Electroconvulsive Suite (ECT) Suite guideline (Ref. 2506)

Te Whatu Ora
Health New Zealand
Waikato

Implementation Plan

ECT Guideline

Document Facilitator:	Matthew Jenkins	Date Prepared:	04/10/23

Actions	By Whom	By When	Resource	Evidence of Completion
Communication An email will be sent to the CNM ECT when the updated version of this guideline is loaded to the intranet. The CNM will then communicate with the ECT MDT at their peer review meeting and with the PACU department via email Availability of the updated guideline will be documented in the November Quality Improvement Newsletter for the Acute Adult and Forensic Service	CNM- ECT	By 30/10/23	Staff time	Email Meeting minutes
Orientation CNS's of AMHS and OPR1 wards will include this document as part of the orientation pack for registered nurses	AMHS and OPR1 CNS	By 30/10/23	Staff time	ECT guideline present in orientation packs
Education ECT CNS will include this document in their scheduled education sessions to Drs and registered nurses This guideline will be added to the Ko Awatea ECT education content CNS will provide 1:1 education on wards	ECT CNS ECT CNS ECT CNS	By 30/10/23 By 29/12/23 By 30/10/23	CNS time CNS time staff time	Education session content Ko Awatea content CNS education records
Additional Resource Required	Nil			

ECT Guideline

Audit Process				
CNS will visit wards to check knowledge of RNs using an audit tool and provide 1:1 education as required	CNS	29/12/23	Staff time	Audit tool records
Yearly patient satisfaction survey incorporating aspects of the guideline	CNS	29/12/23	Staff and patient time	Surveys sent and results received
Staff (RN and DR) education and training session feedback and surveys	CNS	29/12/23	Staff time	Feedback received and collated

Te Whatu Ora
Health New Zealand
Waikato

Consultation Feedback Record

ECT Guideline

Document Facilitator:	**Matthew Jenkins**

Date:	Received from (name):	Department:	Comment:	Comment used in new version of document, if not reason why:
15/09/23	Carole Fairley	Mental Health and Addictions Service Quality Improvement	'Registered' added before all nurse mentions	yes
			In 2.1- ECT nurse- "following direction from others ie PACU nurse, Dr, Anaesthetist not just the ECT CNS	yes
			In 2.2 All registered nurses will have completed the appropriate level of training in relation to their specific role in ECT delivery and resuscitation training as per the Te Whatu Ora Waikato Resuscitation policy (1970).	yes
			Family/whanau replaced with whānau throughout document	yes
			Waikato DHB replaced with Te Whatu Ora throughout document	yes
			In 2.5 In-patients are returned to the ward with an appropriate escort. Mode of transport and RN escort added	yes
			In 4.1ECT providers and ECT registered nurses are supported to attend educational programs and courses in order to remain up-to-date in ECT best practice Responsible Clinicians, assigned nurses and other supporting Mental Health and Addictions Service staff members will have completed Te Whatu Ora- Waikato ECT training specific to their respective roles	yes

			Do they need to be indicators or should they be part of development and performance processes/ credentialing?	
			In 5.2 •Mental Health and Addictions Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff (0451) Changed to Clinical Handover- Mental Health Inpatients wards procedure	yes

Emergency Response Mental Health and Addictions Community Bases

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions Service
Document Facilitator Name	Nicola Livingston
Document Facilitator Title	Operations Manager
Document Owner Name	Sue Critchley
Document Owner Title	Director Community Mental Health and Addictions
Target Audience	Mental Health and Addictions community services staff
Disclaimer: This document has been developed by Te Whatu Ora Waikato specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Te Whatu Ora Waikato assumes no responsibility whatsoever.	

Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
02	Nicki Barlow	March 2021	Update of HTT specific processes

Emergency Response Mental Health and Addictions Community Bases

Contents

Emergency Response Mental Health and Addictions Community Bases

1 Overview

1.1 Purpose

This procedure outlines the roles and responsibilities of the Mental Health and Addiction Service employees (clinical and non-clinical) in responding to emergency situations at community mental health and addiction service bases.

They will respond immediately and accordingly to all emergency situations, managing the safety of tāngata whaiora, whānau, visitors, staff and their environment. The safety of responding staff remains a priority.

Note; whilst non-clinical staff (administrators) do not make up the response team they play a vital role in activating or re-setting duress alarms, locking and unlocking doors and contacting emergency services if directed to.

1.2 Staff group

This procedure applies to all staff working in Mental Health and Addiction Service community bases.

1.3 Patient / client group

Mental Health and Addiction tāngata whaiora and whānau, staff.

1.4 Exceptions / contraindications

This procedure applies to emergency response at the community bases. For emergency response at other places of assessment see the Mental Health and Addiction Home / Community Visits procedure (0901)

1.5 Definitions and acronyms

Emergency	Any situation (perceived or actual) where a response by the service is required to manage the safety of tāngata whaiora, whānau, visitors, staff and the environment. Examples include but are not limited to: perceived or actual threats of verbal or physical assault / harm

2 Clinical management

2.1 Roles and responsibilities

All Staff

All staff who work in community mental health and addiction services must complete orientation to the service and site including use of duress, and emergency response procedures.

All non-clinical staff should attend de-escalation training (front of house) or personal safety training.

Clinicians

All community mental health and addiction service clinicians and community support workers must attend de-escalation training. Training is captured on a training database.

Managers

Managers are responsible for ensuring staff are orientated to the service and site (including protocols and procedures), receive refreshers on emergency processes and have attended de-escalation training.

Ensure adequate emergency equipment is available and in good working order.

Contractors

Follow the directions of the responding team in the event of an emergency.

2.2 Competency required

- Level 2 or Level 4 Resuscitation Training
- De-escalation training or Safe Practice and Effective Communication Training (SPEC). Or personal safety training (non-clinical).
- Completion of Community Mental Health Services site specific orientation training which includes the location and use of emergency equipment and personal safety systems.

2.3 Equipment

- Duress Alarm – located in clinical areas at He Toa Takitini, CBD Waiora and the Community Forensic service. Or alternative alarm methods as agreed by the team and documented in the Departmental Emergency Response Plan at other community bases.
- Mobile phone – carried by all community mental health staff
- Emergency medical equipment
- Automated external defibrillator (AED) as approved by the Waikato DHB Early Detection of Deteriorating Patient Group
- Fire blanket
- Departmental Emergency Response Plans (DERP)

2.4 Procedure

Note: In the event the duress alarm is activated for a second incident the same procedure applies as outlined in this document.

Duress alarm activation at He Toa Takitini, and Waiora CBD

When faced with an emergency, staff should immediately seek assistance by activating a duress alarm.

Duress alarms are accessible in interview rooms and clinic rooms at He Toa Takitini, and alarms are in interview rooms at Community Forensics and at Waiora CBD. Alarms are either attached to a wall and can be removed, or are sitting on desk tops. It is the

responsibility of the clinician to locate the duress before the tāngata whaiora / visitor enters the room.

There is a wall mounted stationary alarm located behind the main entrance reception counter at He Toa Takitini, Hamilton.

Alarm activation will sound throughout the building alerting staff to attend.

The person activating the alarm may choose to also summon additional assistance where the nature of the emergency is obvious, such as, contacting emergency services (police, ambulance or fire).

Duress Alarm / Emergency Alarm response

It is the expectation that when the duress / emergency alarm is activated, staff in the building will respond in person.

Responding staff will assemble outside the centre stairwell on level one at He Toa Takitini (HTT), Hamilton and in the agreed emergency response location at each community base. At HTT a CCTV screen that monitors the reception area is placed on the wall at the bottom of the centre stairwell – response team to check monitor prior to proceeding.

A minimum of four responding staff will make up the response team at HTT, and at other community bases the staff present will make up the response team. One person will take the lead responder role. The forming of the team must occur rapidly to avoid delay with responding to the situation.

The response team is not discipline specific.

The role of the response team is to assess the level of risk and to respond in a coordinated way to ensure the incident is managed in a safe and effective manner through to satisfactory resolution.

The response team will proceed to the incident area.

The lead responder is to direct and oversee the response team, provide support and coordinate additional resources if required. It is important to note that the lead responder may only be in the role until a clinician the person is familiar with is able to attend or handover to another clinician / team for more in-depth assessment to occur.

Interventions may include:

- Clinical assessment with support from other staff
- Calm verbal and non-verbal communication
- Verbal de-escalation and distraction techniques
- Ask the person to leave the building
- Move staff and members of the public to a safer location
- Request a group e-text is sent out to the building at He Toa Takitini to notify of location of incident and advise regarding use of alternative safe entry/exit. Operations manager administrator and other allocated administrators can send a group e-text.

- **Contact the police if immediate safety concerns are identified**
- Request the duress alarm system be re-set at He Toa Takitini – behind the main entrance reception counter at HTT.

The response team will take direction from the lead responder, and be responsible for securing and managing the immediate area.

Personal restraint

Use of personal restraint by community mental health and addiction staff should be avoided unless imminent threat to safety is present.

The NZ Crimes Act 1961 allows the use of force in;

'Self-defence and defence of another:

Everyone is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use'. Section 48 Crimes act (1961).

'Everyone is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence'.

Community mental health clinicians and staff are not trained in restraint techniques. Therefore, the use of any form of personal restraint should only be considered as a last resort to avoid imminent harm to the person or others. Any use of personal restraint / use of force in the community is to be documented in the Datix incident reporting system with information about the reason this intervention was used.

Post event

The response team will ensure that post event activities are addressed:

- Ensure any medical equipment is replaced
- Ensure any property requiring replacing / fixing is reported
- Inform assigned clinic nurse or Administrator – Facilities, of use of emergency equipment

The lead responder will ensure:

- Reception staff switch off the duress alarm at He Toa Takitini and administration staff at other community bases that have a duress system
- Request group e-text to the building to notify the incident is resolved at He Toa Takitini and communication with staff by CNM / delegated person at other community bases.
- Check in with person that initiated the alarm and let them know that the incident has been resolved

- Datix incident reporting is completed. Appropriate Operations Manager to be added as 'Investigator' on Datix (by TL / CNM who receives Datix) to increase visibility of incidents at community bases.
- Verbal handover to the Operations Manager if the nature of the incident indicates urgency of notification who will inform the Director of the service.
- Ensure clinical documentation is completed via clinical workstation including the update of the risk assessment / formulation if required
- Ensure the key clinician and team leader are informed if the incident involves a current tāngata whaiora

All staff involved should be offered the opportunity to diffuse the incident immediately or as soon as possible as a feedback mechanism and to manage / minimise potential post-incident effects on staff. It is the responsibility of the CNM / delegate to facilitate diffusion or organise a formal debrief process if identified as required. The Psychology team are available to support debrief.

Checking of duress alarms

At He Toa Takitini duress alarms are checked bi-monthly by administration.

A periodic beep indicates a low battery which requires immediate attention and a need to change the batteries. At He Toa Takitini ensure the alarm is returned to administration for a change of the battery as soon as noticed.

It is the responsibility of the clinician to orientate themselves to local processes for alarm checking and maintenance.

At CBD Waiora the emergency alarm system is maintained by the building manager. At all other community bases the team leader / charge nurse manager is responsible for ensuring an emergency alarm system checking process is in place.

3 Audit

3.1 Indicators

- All duress alarms present in services are functional and checked regularly
- Staff at community bases have completed the community service base orientation
- Staff have attended de-escalation/personal safety training

3.2 Tools

- Nil incident reports on non-functional duress alarms
- Records on completion of orientation

4 Evidence base

4.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Assaults or Threats towards Mental Health and Addictions Service Staff procedure (Ref. 1857)
- Mental Health and Addictions Home / Community Visits procedure (Ref. 0901)
- Health and Safety policy (Ref. 0044)
- Incident Management policy (Ref. 0104)
- Restraint policy (Ref. 2162)
- Resuscitation policy (Ref. 1970)

4.2 External Standards

- New Zealand Crimes Act 1961
- Health and Safety at Work Act 2015
- Employment Relations Act 2000
- Human Rights Act 1993

Food Safety in Puna Whiti, Puna Taunaki and Ward 41

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff in Puna Whiti, Puna Taunaki and Ward 41
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
04	Kylie Balzer	09 November 2021	Updated into current guideline format and changed from action / rationale format Now includes Ward 41 Change to statement on restriction to food preparation due to illness Feedback from the Manager of Food and Nutrition Services incorporated
03	Amanda Lewis Wilson	17 July 2017	Updated into new guideline format Action 3 Food preparation added Action 4 Food storage added

Food Safety in Puna Whiti, Puna Taunaki and Ward 41

Contents

Food Safety in Puna Whiti, Puna Taunaki and Ward 41

1 Overview

1.1 Purpose

Food borne infection is largely preventable and all staff have a responsibility to ensure the food and beverages that are consumed by our residents are safe for consumption.

To offer guidance to those who prepare food in order to decrease the likelihood of contaminating food and maintain health and safety for all.

Staff to role model and educate whilst supervising or supporting residents preparing and cooking food.

Note: Anybody suffering from vomiting or diarrhoea, raised temperature or acute respiratory symptoms must not prepare food for others until they have been symptom free for 48 hours.

1.2 Scope

This document applies to the preparation of food in Puna Whiti, Puna Taunaki and Ward 41.

1.3 Patient / client group

Residents of Puna Whiti, Puna Taunaki and Ward 41.

1.4 Exceptions / contraindications

This document does not apply to food prepared by Nutrition and Food Servcies under their own procedures.

1.5 Definitions and acronyms

Nil

2 Clinical management

2.1 Roles and responsibilities

All Staff
Have a responsibility to ensure the food and beverages that are consumed by residents are safe for consumption.

Managers
Have a responsibility to ensure equipment required for safe food preparation is available and that monitoring of food preparation areas occurs.

2.2 Competency required

All staff must be aware of likely causes of contamination of food and be able to guide the residents in safe food preparation.

2.3 Equipment

- General household equipment
- Dishwasher
- Refrigerator and freezer

2.4 Guideline

Personal Hygiene

An important way to reduce food contamination is to maintain a high standard of personal hygiene and cleanliness. Hands must be washed using soap, water and paper towels before and after handling food (especially raw meat), before handling clean crockery and cutlery, after handling chemicals, before putting on and after removing gloves, after touching nose, ears, mouth or other parts of the body or soiled clothing, after contact with rubbish bin and dish cloths.

To decrease the likelihood of contamination:

- All cuts and sores must be covered with clean waterproof dressing and gloves must be worn. Anyone with infected sores on hands should not be involved in the preparation of food.
- All long hair must be tied back while preparing food
- Should any food preparation, surface or utensil become contaminated with body fluids staff must decontaminate the area as per infection control procedures before food preparation can continue.

Food Preparation

To decrease the likelihood of contamination work surfaces must be cleaned with a suitable cleaning agent and a clean disposable cloth or paper towel prior to the commencement of food preparation.

To prevent / decrease the likelihood of food borne illnesses staff are to ensure that meat that needs to be thawed is taken out of the freezer and put into a dish that will collect blood as it thaws, and put in the bottom shelf of the fridge to thaw. This means removing meat from the freezer and transferring to the fridge 48-24 hours before using.

To reduce the risk of cross contamination:

- Two chopping boards are provided one for raw meat, including raw chicken, and one for other food items. Ensure the appropriate board is used (as designated) and cleaned thoroughly after use. The raw meat / chicken chopping board is to be cleaned down with a brush and hot soapy water and dried with paper towels between use and it must be cleaned in the dishwasher. The chopping board must not be used for other food preparation.
- Hands must be washed thoroughly each time after handling raw meat. Raw meat and raw chicken must be kept away from all other food on the bench. All raw meat juice

must be cleaned up with a paper towel and then the area cleaned with a suitable cleaning agent and a paper towel.

- Separate knives must be used when preparing meat and vegetables and must be washed thoroughly in hot soapy water between use if using the same knife for meat and vegetable preparation.

Food Storage

To reduce the risk of cross contamination, prevent / decrease the likelihood of food borne illnesses and store food appropriately and safely:

- All left over food must be refrigerated within one hour of being prepared. Food must be covered and dated before being placed into the refrigerator and must only be kept for 24 hours. After 24 hours all food must be discarded. A daily check of the fridge will occur to ensure all food over 24 hours old is discarded.
- Read and follow all food storage instructions on all packaging. Check all expiry dates and dispose of all expired foods.
- The fridge temperature must be monitored daily and recorded and all food stored in the fridge must be according to fridge storage information available on fridge and in the food safety folder.
- Staff are to complete a check of pantry and benches once dinner has been cooked to ensure that food is refrigerated within an hour. Ensure food that is boiling hot is not refrigerated.

Cleaning of Crockery / Cutlery and Surfaces

To prevent / decrease the likelihood of food borne illnesses and to prevent transmission of illness between clients:

- All crockery, cutlery, plastic chopping boards must be rinsed clean and washed in the dishwasher
- All work surfaces and the sink must be cleaned with a suitable cleaning agent and a clean disposable cloth or paper towel after preparation of food.

3 Patient information

Information on the fridge about safe storage of food in Puna Whiti. A food safety folder is available in the kitchens for Puna Taunaki, Puna Whiti and Ward 41.

4 Audit

4.1 Indicators

- Food is covered and dated in the refrigerator and leftover food is not older than 24 hours
- The fridge temperature is recorded daily and corrective action taken if not within recommended levels.
- All staff are trained in this guideline
- Cleaning schedule is completed.

5 Evidence base

5.1 Bibliography

- https://www.mpi.govt.nz/food-safety-for-consumers/

5.2 Associated Waikato DHB Documents

- Lippincott Hand Hygiene NZ Clinical Procedures
- Lippincott Infection Control Clinical Procedures
- Waikato DHB Linen – Imprest Stock Levels and Pre-Laundry Process Procedure (2454)

5.3 External Standards

- Health and Disability Services Standards 8134: 2008 until the 28 February 2022 and following this Health and Disability Services Standards 8134:2021

Home / Community Visits

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Nicola Livingston
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
09	Nicola Livingston	October 2022	Changed to Te Whatu Ora template Full document review completed Language changed from Waikato District Health Board to Te Whatu Ora Purpose of procedure wording changed to better reflect guiding of practice Section 2. Inclusion of statement about effective clinical management Consistent use of tāngata whaiora and whānau 2.4 statement about supporting home visits changed to be clearer and including constraints of resources Inclusion of expectation for clinicians to review available risk information prior to community/home visit Review of clinical processes – requirements of clinician / support worker
08	Nicola Livingston	May 2019	Changed from policy document to procedure Change of title from Home Visits to Home / Community Visits

Home / Community Visits

Contents

1 Overview

1.1 Purpose

The purpose of this procedure is to guide practice that optimises the safety of clinicians, tāngata whaiora and whānau when services are being provided in the community and away from mental health and addictions service bases. Least restrictive practice principles and a commitment to closer to home service provision encourages this practice where clinically appropriate.

1.2 Scope

This procedure applies to all employees and services offered by Te Whatu Ora Waikato Mental Health & Addiction services.

1.3 Patient / client group

Any tāngata whaiora seen by the Mental Health and Addictions service within a community setting.

1.4 Exceptions / contraindications

No exceptions.

1.5 Definitions and acronyms

Community visit	Meeting with tāngata whaiora / whānau in a community area e.g. café, park
Home visit	Meeting with tāngata whaiora / whānau at their place of residence
Safety	Safety in the widest interpretation including cultural safety and personal safety
Culturally appropriate	Respectful of Māori, other ethnicities and cultural uniqueness

2 Clinical management

Effective clinical practice involves engagement with tāngata whaiora and their whānau in a way that enables their inclusion in their recovery journey. Visiting with tāngata whaiora and their whānau in their homes or community is a key mechanism to enhance ongoing engagement and relationship building.

2.1 Roles and responsibilities

All Staff

- Are responsible for promoting a safe environment for themselves, their colleagues, tāngata whaiora, whānau and general public.
- Are responsible for completing de-escalation for community clinicians training and ensuring they keep up to date with required skills
- Are aware of, and understand, the risks when working in the community, and take steps to mitigate the risk as much as practicable.

Clinicians

- Are responsible for identifying, in consultation with tāngata whaiora and whānau, the most appropriate place for tāngata whaiora and/or whānau interactions to take place. Clinicians will support home / community visits as much as possible.

Managers

- Managers must ensure a process is in place at each base to identify that all staff have returned to the base at the end of the working day.
- Managers must ensure that all staff are aware of risks to themselves, their clients/whanau when working in the community, and have completed required training.

2.2 Competency required

- Registered health care professional
- Support worker or psychiatric assistant under the delegation of a registered health professional
- Completion of the mandatory training “De-escalation for community clinicians” and have kept themselves updated utilising self-directed learning available through Ko Awatea online training modules such as ”Introduction to Personal Safety” and “CALM Communication”.

2.3 Equipment

- Te Whatu Ora staff identification (currently also Waikato DHB ID)
- Working cell phones
- Mental Health and Addictions form / alerts system for documenting alerts
- Te Whatu Ora Waikato fleet car
- Duress systems / alarms on car keys
- Electronic calendar
- Based on physical health questions, appropriate PPE

2.4 Procedure

Underlying principles

- Home / community visits are a valuable component of assessment and treatment and an integral part of the clinical treatment process
- Home / community visits will be supported as much as possible except where specific circumstances, such as the safety of clinicians, tāngata whaiora, whānau or the public are compromised or insufficient resources within the team impact on the ability of staff to provide a home visit.
- Home visits are carried out in a manner appropriate and respectful to the culture of tāngata whaiora / whānau members.

Safety principles

- Te Whatu Ora community mental health and addictions service bases will have a system in place to ensure the whereabouts of the clinician is known, and identify when a clinician has not returned or checked in from a home visit within 2 hours of their scheduled return to base. The charge nurse manager / team leader or delegate will follow-up on the staff member's whereabouts.
- Staff are trained in managing their own safety and that of their colleagues
- Where safety concerns have been highlighted an appropriate action plan is developed by the clinician in consultation with the MDT and / or manager, and documented in CWS. This may, for example, include two clinicians attending visits or an appointment being offered at base until safety concerns are addressed / mitigated.
- Patient alerts are noted on the alerts form and in the iPM system, for example dogs on premises or history of volatile/aggressive behaviour.
- Where appropriate an initial assessment or first contact following transfer of care to a new treating team or keyworker is completed at the clinical base. As much as possible the clinician should meet tāngata whaiora prior to the transfer of care i.e. inpatient unit or with the previous clinician when transferring from another team.
- Clinicians visiting correctional facilities or other businesses must comply with the safety precautions in place at the facility.

Clinician processes for promoting safety for home /community visits

At all times the clinician / support worker will:

- Use only a Te Whatu Ora Waikato fleet vehicle for home / community visits
- Carry car keys in an easily accessible place
- Ensure their electronic calendar is kept up to date with appointment details
- Share their electronic calendar with the Team Leader / Charge Nurse Manager to ensure visibility of whereabouts at all times
- Have a functional mobile phone which has emergency numbers programmed in
- Consider their own safety to be important

- Be prepared for adverse weather conditions and emergencies whilst travelling, especially in rural areas
- Call back to their Team Leader / Charge Nurse Manager if they are running late and / or if they have changed their plans whilst out in the community and are visiting a tāngata whaiora / whānau or location not identified in their electronic diary
- Know the address of where they are visiting and have access to a map / GPS
- Have two members of staff present if making a home / community visit in a crisis situation or where there are identified risks / uncertain risk.

Prior to the home / community visit the clinician / support worker will:

- Consider the appropriateness and benefits of a home / community visit compared to scheduling an appointment at a Mental Health and Addiction Service community base
- Review and understand the available risk information about tāngata whaiora, and discuss same in MDT or daily planning meeting, to identify actions to mitigate the risk as much as practicable
- Contact tāngata whaiora and ask physical health questions (contagious – covid-19, flus, colds, any other contagious illnesses present in the home).
- Ask the tāngata whaiora to secure any animals of concern
- Have scheduled an appointment with tāngata whaiora as much as possible whilst recognising at times unscheduled appointments may be necessary.

At the time of the home /community visit the clinician / support worker will:

- Park their car on the roadside as much as possible or in such a way that allows for ease of exit and in an area that is in full view
- Consider exits and locate self near or close to an external exit where possible
- Ensure that the fleet car is locked and only carry what is necessary for the visit
- Demonstrate / show respect for tāngata whaiora / whānau home as a visitor
- Remain in common areas of the home and be careful in respect to the safety of any furniture being used
- Demonstrate culturally appropriate behaviour and have regard for possible issues of stigma associated with the visit
- If the tāngata whaiora does not want to let the clinician/support worker in to their home, the clinician /support worker should leave the situation and later call the tāngata whaiora to discuss.
- If during a home / community visit, clinicians / support workers have concerns of:
  - children who are unsupervised
  - family / whānau harm, violence or abuse
  - abuse towards animals

o illegal activity or firearms,

they should discuss this with their charge nurse manager / team leader immediately and the appropriate services notified.

- Clinicians / support workers should leave the home / community environment at any time they feel unsafe or if they suspect the presence of drugs, firearms or illegal activity and discuss this with their charge nurse manager / team leader immediately
- Clinicians / support workers should not enter a home / community environment if there is no means of quick escape, vicious animals are present, or intoxicated, violent / threatening people are present.

If overdue from a home visit the clinician / support worker/s will:

- Advise the charge nurse manager / team leader or delegate if overdue from a home visit or there is a change in plans
- Contact the charge nurse manager / team leader to inform them they are safe when they have returned to base.

Charge Nurse Manager / team leader or delegates processes:

- The charge nurse manager / team leader or delegate will ensure that all clinicians / support workers have returned to the base at the end of the working day or they are aware of their whereabouts
- If a clinician / support worker is overdue, and they have not contacted the team leader /change nurse manager they must be contacted by cell phone
- If unable to be contacted, attempt to locate the staff member using Smartrak tracking system by contacting the administrators. If the vehicle cannot be located, attempt to contact the last tāngata whaiora that the staff member had scheduled to visit that day.
- If still unable to locate the staff member, the Charge Nurse Manager / Team leader will notify/inform their Operations Manager
- If within business hours, and where able to, at least two available team members may visit the last known home visit address to check if the Te Whatu Ora vehicle is present.
- If the vehicle is present, attempt to contact the staff member, or tāngata whaiora again, to ask them if the staff member is at the property. If no answer, a decision will be made in consultation with Operations Manager to approach the property or to call the Police to complete a welfare check, and provide relevant details (i.e. based on information held on the clinical files which may also include a risk form)
- The manager will make a decision in consultation with Operations Manager to notify the Police of a missing person if unable to contact the staff member.

Following an incident:

- All staff involved in an incident will have the opportunity to debrief / reflect
- Staff members are reminded of their ability to access the Employee Assistance Programme (EAP) as necessary
- All appropriate documentation regarding the incident is completed inclusive of a DATIX incident report.

3 Patient information

Each tāngata whaiora / whānau must be provided with the appropriate service specific information brochures and access to information on the Code of Health and Disability Consumers' Rights.

4 Audit

4.1 Indicators

- Mental Health and Addictions services continue to be delivered in the least restrictive environment in the community while maintaining the safety of clinicians / support workers, tāngata whaiora and whānau.
- There is a staff whereabouts tracking system in place which is 100% compliant with this procedure.

4.2 Tools

- Team Leaders will monitor the number of service user attendances at the community base and the number of home / community visits
- Team Leaders will audit compliance with the tracking system at least annually.

5 Evidence base

5.1 External Standards

Te Whatu Ora Waikato must comply with the following legislation (this list is not exclusive):

- Health and Safety at Work Act 2015
- Human Rights Act 1993
- Privacy Act 2020
- Employee Relations Act 2000
- Treaty of Waitangi Act 1975
- Code of Health and Disability services Consumers'' Rights Act 1994
- Health and Disability service Standards NZS 8134: 2008

- Mental Health (Compulsory Assessment and Treatment) Act 1992 and Amendment Act 1999
- Criminal Procedures (Mentally Impaired Persons) Act 2003
- Intellectual Disability compulsory Care and Rehabilitation Act 2003
- Substance Addiction (Compulsory Assessment and Treatment) Act 2017

5.2 Associated Te Whatu Ora Documents

- Clinical Records Management policy (0182)
- Critical Incident Management for Staff policy (0175)
- Employee Assistance policy (0286)
- Employee Information policy (1775)
- Incident Management policy (0104)
- Managing Behaviour and Performance policy (5250)
- Māori Health policy (0108)
- Mental Health Risk: The assessment and management of service users at risk of harm to self or others procedure (5241)
- Vehicle Usage and Safe Driving policy (0112)
- Violence Intervention Programme policy (6313)

Mental Health & Addictions Services, Integrated Care Pathway

Policy Responsibilities and Authorisation

Department Responsible for Policy	Waikato DHB, Mental Health & Addictions service
Document Facilitator Name	Rachael Aitchison
Document Facilitator Title	Director: Acute, Forensic & Specialty Service
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff
Committee Approved	Mental Health Clinical Governance Forum
Date Approved	20 May 2019
Committee Endorsed	Board of Clinical Governance
Date Endorsed	14 June 2019

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Policy Review History

Version	Updated by	Date Updated	Summary of Changes
02	Rachael Aitchison	March 2019	Change from circle of care to multidisciplinary team and other minor wording changes

Contents

1 Introduction

1.1 Purpose

The purpose of this policy is to outline the set of standard expectations for the care of all people referred to the Mental Health and Addictions service. In this policy the term "integrated care pathway" is used to refer to a key strategy for ensuring care is managed and organised in a standardised manner (see Appendix B, definitions and acronyms).

The Mental Health and Addictions service will deliver coordinated care by means of an integrated care pathway. This policy provides the outlines of the essential set of standardised care inputs which affect progressive service user flow through services. The Mental Health and Addictions service recognises that health care is unique to the service user and variations to the pathway may occur. Ongoing monitoring of variations in care delivery will be part of the learning and continuous improvement process with the service. When they do, variations in care will be monitored as a response of learning and continuous quality improvement.

1.2 Background

Waikato DHB Mental Health and Addictions services recognises its responsibility for providing safe, effective and efficient mental health care for service users1 and their whānau, and other carers.

1.3 Scope

This policy is to be used for all service users referred to Mental Health and Addiction services. It applies to all clinical employees, students and contractors working within the Mental Health and Addictions service and describes the responsibilities of both managers and other individuals in relation to service delivery. It highlights the key accountabilities for the governance forums, and other individuals in relation to quality of care.

2 Definitions and Acronyms

The following definitions are used through the document.

- ***Addiction***
  Addiction in this document relates only to alcohol and other drug use and/or problem gambling.

- ***Alcohol or any other Drug Clinician***
  Offer recovery focused services for individuals with addictions (as outlined above)

- ***Assessment***
  A service provider's systematic and ongoing collection of information about the needs of a person. A clinical assessment forms the basis for development a diagnosis and an individualised treatment and support plan with the service user and their carer.

- ***Clinical practice guidelines***
  Clinical practice guidelines describe best evidenced clinical choices to treat a specific disorder. they can be found here https://www.ranzcp.org/publications/guidelines-and-resources-for-practice

- ***Bio-psycho-social***
  The bio-psycho-social model is a general model or approach stating that biological, psychological (which entails thoughts, emotions, and behaviours), and social (socio- economical, socio-environmental, inclusive of cultural and spiritual factors, their complex interactions all play a significant role in understanding health, illness, and health care delivery.

- ***Clinical record***
  Information about the physical or mental health of a service user, which has been made by, or on behalf of the multidisciplinary team (which is recorded either electronically or in a paper file).

- ***Clinical psychologist***
  Clinical psychologists apply psychological knowledge and theory derived from research to the area of mental health and development, to assist children, young persons, adults and their families with emotional, mental, development or behavioural problems by using psychological assessment, formulation and diagnosis based on biological, social and psychological factors, and applying therapeutic interventions using a scientist -practitioner approach. Such practice is undertaken within an individual's area and level of expertise and with due regards to ethical, legal, and the New Zealand Psychologists Board-prescribed standards.

- ***Consultant psychiatrist (SMO – senior medical officer)***
  A qualified doctor who has completed special advanced training in diagnosing and treating mental health illness or disorders.

- ***Crisis***
  Crisis is viewed as a turning point towards health or illness, a self-limited period of a few days to six weeks in which environmental stress leads to a state of psychological disequilibrium. Crisis is defined on the basis of the severity, not the type of problem facing the individual, and whether any acknowledged trigger factors for a crisis are present.

- ***Diagnosis***
  Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and possible causes for the symptoms. DSM IV or ICD 10 classification systems for are used for diagnosis.

- ***Evidence-based practice***
  An approach to decision-making in which the health practitioner/s uses the best evidence available, in consultation with the service user, to decide on a course of action that suits the person best.

- ***Family Whānau***
  The service user's whānau, extended family, partner, siblings, friends or other people that the service user has nominated as a carer (see other carer).

- ***History***
  When a healthcare professional obtains an account from a person, and usually a carer/relative, of how an illness or disorder has developed, together with details of the person's social and personal background. A diagnosis is usually made on the basis of the history that has been obtained, a mental state assessment, a physical examination and other necessary investigations.

- ***HoNOS***
  Health of the National Outcome Scale.

- ***Integrated care pathway***
  An integrated care pathway (or ICP) is an outline of anticipated care, placed in an appropriate timeframe to help a service user move progressively through a clinical experience to improved outcomes

- ***Intervention***
  Healthcare action intended to benefit the service user.

- ***Kaitakawaenga***
  Cultural facilitators that work specifically with tāngata whaiora Māori, conduct cultural processes, assessments and interventions

- ***Key worker***
  Is a registered health professional / health practitioner or social worker eligible for registration. He/she coordinates (but does not necessarily provide) all care for the service user, including external agency input. He/she is responsible for coordinating the treatment care / recovery / relapse prevention planning process, including transfer of care planning, and all documentation. He/she is the service user and whānau primary point of contact within the service.

- ***Mental health***
  A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.

- ***Mental health (registered) nurse (definition extracted from NZNC Scope of Practice)***
  Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practice independently and in collaboration with other health professionals, perform general nursing functions, and delegate to and direct enrolled nurses, health care assistants and others. They provide comprehensive assessments to develop, implement and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings and partnership with individuals, families, whanau and communities

- ***Mental illness***
  A general term for a wide range of disorders where mental functioning such as perception, memory, emotion or thought is affected.

- ***Multi-disciplinary team***
  A group of registered health professionals / health practitioners who work together to determine goals, evaluate outcomes, and make recommendations and deliver bio-psycho- social and cultural interventions and treatment to assist

in the service user recovery at a particular point in time. An MDT collaborates across the system to ensure the needs of the individual and their whanau are met.

- ***Occupational therapist***
  Occupational therapy is a person-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable service users to participate in the activities of everyday life. Occupational therapists achieve this by working with service users, whānau and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

- ***Outcome***
  The end result of care and treatment and/or rehabilitation. In other words, a measurable change in health, functional ability, symptoms or situation of a person, which is attributed to interventions and/or rehabilitation or services.

- ***Other carers***
  Other carers, who may be whānau or close friends, have a major role in supporting people with mental health difficulties to recover or cope as best they can with the condition.

- ***Prescription***
  A set of written instructions from a doctor to a pharmacist regarding the preparation and dispensing of a medication, etc for a particular patient.

- ***Primary care***
  The conventional first point of contact between a service user and MH&AS. This is the component of care delivered to service users outside hospitals and is typically provided through their general practitioner (or GP).

- ***Psychiatry***
  A branch of medicine concerned with the diagnosis, care and prevention of mental illness.

- ***Psychosocial***
  Relating social conditions to mental health.

- ***Recovery***
  Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). The term is also used to describe recovery from an addiction

- ***Recovery Approach***
  People living well in the presence or absence of mental illness. The alcohol and other drug sector have a similar yet different view of recovery, one that includes both abstinence and harm minimisation perspectives that have evolved over time, allowing service users a choice to adopt the approach that best represents their world view.

- ***Recovery plan***
  A written protocol of care which is developed with the user, and which specifies the roles and responsibility of all individuals involved in the person's care and

when their care arrangements are to be reviewed, (may also be referred to as a treatment plan)

- ***Resident Medical Office (RMO) / Resident Doctor***
  A term that covers house officers and registrars. RMOs or resident doctors may also be known as junior doctors in some countries.

- ***Registered health professional / health practitioner***
  A health professional means a person whose profession is appointed by or under the Health Practitioners Competence Assurance Act 2003 or Social Work Registration Act 2003.

  A health practitioner means a person who or is deemed to be, registered with an authority as a practitioner of a particular health profession, or a social worker eligible for registration.

- ***Referral***
  The process by which a service user is transferred from one professional to another, usually for specialist advice and/or treatment.

- ***Relapse***
  The worsening of symptoms which a person is experiencing, or the return of symptoms associated with an illness.

- ***Risk management***
  A systematic approach to the management of risk, staff and service user safety. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.

- ***Service user***
  A person who uses mental health services. Some people do not identify with the term 'user' and may instead prefer 'patient', 'client', 'consumer' and/or 'tāngata whaiora' (or whatever people choose to name their experience).

- ***Service user journey***
  The pathway through the mental health services taken by the person who is receiving care and treatment, and as viewed by that person.

- ***Social Work***
  Social work is a practice-based profession that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.

- ***Standard***
  Agreed level of performance.
- ***Tāngata whaiora***
  People seeking wellness, mental health service users.

- ***Transfer of care***
  A transfer of care marks the end of an episode of care. Types of transfers of

care include inpatient, day-case, care from specific professionals and transfer from the care of MH&AS service.

- ***Treatment***
  To organise and manage healthcare and related service for a person (this may include cultural approaches)

2.1 Acronyms

The following acronyms are used through the document.

ADOM	Alcohol and Drug Outcome Measure
AOD	Alcohol and other drugs
DHB	District Health Board
HoNOS	Health of the Nation Outcome Scale
ICP	Integrated care pathway
KPI	Key performance indicator
MDT	Multi-disciplinary team
MHA	Mental Health (Compulsory Assessment & Treatment) Act 1992
MH&AS	Mental Health and Addictions service

3 Integrated Care Pathway Policy Statements

Mental Health and Addictions service is committed to ensuring a culture of improved mental health status for people with severe mental health illness. This culture will be achieved, in part, through the systematic management and organisation of care focused on progressive and supported transition through services:

1. **Informing and educating service users and whānau of the recovery approach, the integrated care pathway ethos and the values (person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive) approach to recovery oriented service delivery.**
2. **Assessing each service user's individual risk and vulnerability using the Mental Health and Addiction service Risk Assessment Tool on an ongoing and dynamic basis working together to minimise any risk concern/s identified.**
3. **Ensuring all service users and whānau know who their keyworker is.**
4. **The service user's complexity of need may determine when care is delivered. Ensuring all service users and whānau, and relevant primary care providers have been involved in the transfer of care process through their contributions from the onset and throughout the pathway of care delivery.**
5. **Ensuring that continuous quality improvements are designed, implemented and evaluated to minimise risk and improve service delivery.**

4 Integrated Care Pathway Policy Processes

4.1 Responsibilities

	The service user integrated care pathway journey is everyone's responsibility within Mental Health and Addictions service and therefore requires a whole of service approach with clear points of responsibility and accountability for the management and coordination of care inputs. The following outlines the key responsibilities for all health professionals working at all levels in Mental Health and Addictions service. **Note:** Not every type of staff type has been listed.
All MH&AS employees	**All Mental Health and Addictions employees are responsible for:** • ensuring a commitment to the service goal including: o fostering a person-centred and whānau inclusiveness environment for service users, and an understanding of the Code of Health and Disability Services Consumer Rights 1994 o fostering an environment where the philosophy of recovery principles are encouraged o fostering an environment where bio-psycho-social intervention responsiveness and cultural responsibility is encouraged
Ward / team / line managers	**Ward / team / line managers are responsible for:** • ensuring participation in the implementation of person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive to interventions and the integrated care pathway as required • assisting in the performance focus of teams through monitoring and providing feedback on indicators • ensuring appropriate resources are available to support multi- disciplinary or multi agency team functioning • ensuring safe and progressive service user flow and appropriate transfer and transition of care by facilitating partnerships across services

Operations managers	**Operations managers are responsible for:** • managing resource to appropriately meet service demand and capacity to support service user and staff safety • reviewing and overseeing the care input which affect demand on services • fostering an environment where service delivery risk escalation and management is encouraged • facilitating the implementation of change and ensuring overall quality of service delivery • assisting in the management of resources for continuous improvement learning and develop of staff competency and capability
Consumer roles	**Consumer roles are responsible for:** • ensuring service users are involved at all levels of the organisation • fostering an environment of partnership which reflect recovery principles • facilitating education and staff development training to support person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive interventions including the bio-psycho-social and cultural
Clinical specialists / educators	**Clinical specialists / educators are responsible for:** • facilitating professional education and staff development training to support continuous quality improvement and standards of practice • ensuring an effective framework is in place for auditing and disseminating feedback on variances
Heads of disciplines/Professional Leads	**Heads of disciplines/Professional leads are responsible for:** • ensuring appropriate bio-psycho-social and cultural interventions are being delivered • ensuring that clinical interventions are being carried by staff with the appropriate scopes of practice and/or skills • ensuring that each profession maintain their own professional skills
Governance groups / Directors and clinical Directors	**Governance groups and Directors and Clinical Directors are responsible for:** • ensuring an effective focus on key performance indicators and the quality framework are in place • facilitating and ensuring compliance with external and internal key performance reporting and quality requirements • monitoring compliance with the integrated care pathway in accordance with this policy

Key worker	**Key worker functional responsibility includes:** • facilitating the service user through the integrated care pathway and acting as the first point of contact for the service user, whānau and other carers (Mental Health and Addictions key worker policy 0899) • acting as a communication resource and coordinator for other members of the multi-disciplinary team, services or agencies involved in the delivery of care • fostering an environment of continuity of care and managing transitions of care through the pathway within planned timeframes • ensuring appropriate knowledge and links with Mental Health and Addictions service, primary care services and other agencies to guide and inform service users
Multi-disciplinary Team (MDT)	**Multi-disciplinary team members functional responsibility includes:** • ensuring effective participation with the wider care team, multi- disciplinary or multi-agency team involved in the delivery of care through contributing to assessment and interpretation of information or outcomes • ensuring an ability to work in partnership with service users and whanau • ensuring the appropriate collection and use of HoNOS and ADOM data • fostering an environment of respect and an ability to work in a collaborative way through clarity about role and purpose of the team and individual members.

5 Integrated Care Pathway Process

e service user journey is a continuous process that has many components. It is not simply about tasks. The integrated care pathway management process involves a number of steps.

1. Contact / referral

People seeking assistance or referred to our Mental Health and Addictions service will have their information recorded. There are a number of options available to make a referral including:

- self-referral (e.g. walk-in to Mental Health and Addictions service)
- carer (e.g. whānau member, member of the public, police, or other individual who has a role in providing support)
- primary care practitioner
- secondary care practitioner (e.g., emergency department)
- or other agency (e.g., probation services)

The service user's ethnicity (self-identified) and whānau or support carer (who the service user agrees should be involved in their recovery care) are identified at the initial point of service contact.

Mental Health and Addictions will ensure a standardised approach for managing all referrals to enable prompt and accurate identification of service user needs, urgency and preliminary assessment of risk.

2. Initial screening referral

Mental Health and Addictions will have standardised referral systems in place to manage referrals into mental health services. A set of criteria will be used to allow service user to be signposted to the most appropriate service and reduce wait times based on level of urgency and complexity of need. This may include referral to a more appropriate service provider or agency.

3. Triage assessment

Triage is a clinical process to assess and identify the needs of the person and the appropriate response required. The team managing the entry to services will have the functional responsibility for coordinating the service user care until transfer of care to the appropriate agency or team for follow up has occurred.

A triage or intake assessment will be undertaken using the appropriate assessment form. Ethnicity is a vital demographic and collection of ethnicity data must comply with policy (Waikato DHB Ethnicity data collection policy 0100). Typically the mental health triage is conducted by telephone contact, and can be conducted in person (face-to-face). Additional information may be required from the referrer.
Further information may be sought by whānau or other carer. Triage may also include triage for addictions.

4. Entry	The referral, triage assessment and any other relevant information may be discussed within other clinicians, including a Psychiatrist. Entry recovery care planning formulation discussion will identify: a) long term care - a scheduled identified appointment to the most appropriate member of the Mental Health and Addiction service will occur so that a comprehensive assessment can be carried out prior to the presentation of the referral to a multi-disciplinary team OR b) short term care - assisted referral facilitation of access to advice and information on other services where Mental Health and Addictions service intervention is not required. Other services such as: o general practitioner o health service or agency (not Waikato DHB Mental Health and Addictions) o non-government organisation o specialist mental health service o information for possible future referral
5. Comprehensive assessment	Persons entering a community long term care pathway who have complex need requiring multi-disciplinary or multi-agency input must receive a comprehensive (holistic) assessment and/or cultural assessment. The comprehensive assessment covers the bio-psycho- social and cultural environment elements specific to the service user.it may also include current and past alcohol or other drug history. The assessment is done with the service user by an appropriately skilled and qualified health professional to deal with the type and level of assessment. The holistic assessment will guide decisions regarding multidisciplinary care members. The assessment will be shared with the service user, and with their consent with their whānau. [Note: the comprehensive assessment and evaluation may be updated and the recovery plan amended as the service user progresses through their journey of care]. For people who identify as Māori in inpatient and or have a specific cultural issue in a community, it is important to consider unique aspects relevant to their specific journey. This may necessitate access to input from Te Puna Oranga Kaitakawaenga. For people from minority communities this may require input from a trained interpreter and/or independent advocates (Waikato DHB Interpreters policy 0137).

6. Admission to service	The referral, comprehensive/cultural assessment and any other relevant information will be presented in full and actioned at the multi-disciplinary meeting. Recovery care plan formulation discussion will be identified based on the assessment including: o trigger areas for further assessment, including referral for cultural assessment o agree eligibility for appropriate Mental Health and Addictions service o allocation of key worker and other disciplines' intervention as identified in the assessment. On admission to the long term care pathway inpatient, specialty and community teams have responsibility for ensuring clinical documentation includes: o the rationale for admission to the service o any alternative options considered o the aims of admission to the service o the expected and actual length stay o the plan for transfer of care
7. Recovery planning	A full recovery plan is identified based on the comprehensive and/or cultural assessment and multi-disciplinary discussion. The team will focus on the service user placing varying degrees of emphasis on the distinct elements of bio-psycho-social and cultural interventions to debate recovery approaches and planning including: o diagnosis o set recovery goals and objectives o identify bio-psycho-social and cultural interventions and treatments o identify members of the team (and external agency/s) who need to provide action/input o develop a recovery plan that includes practical coping strategies the service user can use when early warning signs are identified o set transfer of care goals The recovery plan will be developed in consultation with the service user and/or whānau (as appropriate). Any advanced directives identified must be taken into account in plan development. The advanced directive is to be developed with the service user and a copy of the advanced directive is to be provided to the service user (Mental Health and Addictions Advanced Directives Procedure 2181).

8. Intervention phase	The intervention and care management phase will be delivered through a person-centred, culturally responsive, recovery focused, bio-psycho- social- whānau inclusive approach to recovery. The recovery care plan will detail the type and timing of interventions. During the intervention phase the key worker will facilitate: o timing of planned interventions o assess the person's needs and level of risk o monitor the recovery plan o arrange for appropriate care to be provided o monitor the quality of care and psycho-education provided o maintain contact with the person o follow-up on all 'did not attend' (or DNA) on pre-arranged appointments (Mental health and Addictions Appointment planning and the management of DNA's with service users / tāngata whaiora 0900) o liaise with whānau and carers The service user's record shows that a treatment pathway based on the recovery care plan, is followed.
9. Recovery review	The recovery review will be an inclusive process with the service user and/or whānau (as appropriate). The recovery care plan must be formally reviewed as necessary or when there is a change in the service user circumstances that warrant a review (i.e., reviewed at least every 91 days in the community setting and weekly in the inpatient setting or earlier dependent on recovery plan objectives).. The keyworker (who is also actively involved clinically with the person) liaises with and reviews the progress with other team members involved. The outcome of the recovery review will be documented and discussed with the wider multi-disciplinary team as indicated by the level of risk and complexity.

10. Transfer of care	Careful consideration should be given to alternative services capable of meeting the service user's needs. Effective transition or transfer of care from one setting to another should begin as early as possible from the time of admission and should involve the multi- disciplinary team (including multi-agencies, the service user and whānau). For people who identify as Māori in inpatient, it is important to consider a Māori cultural process of poroporoaki/ farewell or transfer of care to the whānau/ community, conducted by Kaitakawaenga. The transfer of care process should include: o updated formulation o impending transfer o areas of potential concerns and strategies to overcome these o likely course of recovery / rehabilitation o follow-up arrangements – including preferred ongoing health provider and identifying other people likely to be involved o crisis plan/early warning signs and plan o re-entry to Mental Health and Addictions process o any other relevant details as identified by the person who receives the service and their whānau o evidence of multi-disciplinary team discussions rationalising transfer of care The transfer of care process should be a seamless process, ensuring that appropriate services are in place to support the service user. The transfer of care needs to be well coordinated, based on the service user's assessed needs, reviewed regularly, and include ongoing risk assessment and management (which includes information for possible future referral).

11. Supported assisted referral

To ensure safe and effective supported and assisted transition of care from Mental Health and Addictions the agreed involvement of primary and community health care is important from the onset and through the pathway of care. To support this process the collection of social indicator (i.e., general practitioner, employment and housing status) information will occur at the point of initial contact to inform the recovery plan. The change in social status at the point of initial contact and at the point of transition from Mental Health and Addictions service will be collected and monitored.

For a referrer, there are likely to be a number of options available locally to make regarding seeking and providing advice or assisted referral prior to transfer of care (includes but not limited to):

- general practitioner
- health service or agency (not Waikato DHB Mental Health and Addictions)
- non-government organisation
- specialist mental health service
- information for possible future referral

There will be systems in place for staff to ensure their awareness about local primary and community stakeholders and services

6 Integrated Care Pathway Tools

Care Assessment Tools

The below list identifies tools that can be used to structure the often complex assessment of need and risk management process. Any assessment needs to balance care needs against risk needs and emphasises:

- positive risk management
- importance of understanding and responding to vulnerability
- collaboration with the service users and whānau
- importance of recognising and building on the service user's strengths
- role in risk management

Triage assessment

An initial triage assessment is undertaken with the person.

- a triage assessment is carried out with the person that obtains sufficient information to:
  - determine whether the person requires a mental health intervention
  - identify possible symptoms of acute mental health illness
  - identify possible suicidal behaviour or thoughts
  - determine the level of risk of harm to self or others
  - determine the level of risk of harm from others
  - determine level of risk of harm to children (includes unborn child)
  - determine compounding addictions issues
  - when Mental Health and Addictions bio-psycho-social intervention is not required, identify the service most likely to meet the needs of the person
  - give the person clear and concise information about the services available and options for further assessment or treatment
- refer the person to the service likely to meet the identified need for further comprehensive or cultural assessment or short term intervention
- triage can be completed for all people existing or unknown to the service

Comprehensive assessment

A holistic comprehensive assessment is undertaken with the service user.

- a comprehensive assessment is carried out with the service user that identifies:
  - current and past mental health history (including the carer's perspective)
  - current and past interventions (including outcomes, adverse reactions and side-effects)
  - personal, whānau and social circumstances
  - mental state examination

  - strengths and aspirations
  - functioning
  - service user needs assessment (and, where appropriate, carer needs assessment)
  - capacity to consent to care and treatment
    - legal status
    - enduring power of attorney (or EPOA)
  - risk (including falls)
  - substance (smoking, drug and alcohol) use, abuse and misuse
  - social indicators
  - provisional formulation and recovery pathway
- a target time for completion of the comprehensive assessment is recorded
- For people who identify as Māori in inpatient and or have a specific Māori cultural issue in the community, it is important to consider unique cultural aspects relevant to their specific journey. This may necessitate access to input from Te Puna Oranga Kaitakawaenga and a cultural assessment as per Waikato DHB Tikanga recommended best practice guidelines.

Assessment and management of risk	A risk assessment, formulation and management process is carried out (Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others procedure 5241). • there is a record of the service user's vulnerabilities and risks, including: o self-harm o suicide o harm to or from others o occupation o vulnerability (e.g., social, sexual, cultural) o abuse (e.g., violence, physical, psychological and emotional, financial / material, sexual) o neglect (includes, active, passive or self-neglect) o carer risk assessment, where relevant • the risk assessment leads to the generation of a risk formulation and management plan that is: o developed with the service user and whānau o communicated to all those involved and identifies roles and responsibilities o reviewed at regular intervals (i.e., reviewed at least every 91 days in the community setting and daily in the inpatient setting or as a new risk is identified) o amended as necessary • serious incidents or near misses are reported in accordance with policy (Waikato DHB Incident management policy 0104) • consider advice from a Duly Authorised Officer (DAO) regarding the Mental Health Act 1992
Physical health assessment and management (see Appendix A, flowchart for metabolic monitoring)	A general physical health assessment and management of the findings are recorded. The clinical record shows that physical health needs are assessed at least every 6 months in the community setting and daily (as clinically indicated) in the inpatient setting (or earlier dependent on results) using the following features

	• the completion of a physical health assessment o vital signs o physical examination o risk factors at assessment o lifestyle risk factors o family history risk factors o assessment summary and management plan • the provision of health promotion advice • service users receiving medication should have side-effects and physical health assessed and managed according to the appropriate clinical guideline for that medication (e.g., clozapine) The clinical record shows information on the management of physical health needs, including; o information on who is responsible for the physical health assessment o evidence that results have been shared o evidence that results have been acted on o evidence that information and/or advice on promoting a healthy lifestyle has been provided
Diagnosis	There is a record of a diagnosis or diagnoses. The clinical record shows: o the diagnosis or diagnoses o information on how the diagnoses were reached following evidence based guidelines or established diagnostic criteria, where available o confirmation that the diagnoses have been explained to the service user and whānau o post-diagnosis support is offered
Suitability for bio-psycho-social and cultural interventions	The need for structured bio-psycho-social and cultural interventions for the service user is assessed. • the assessed need for bio-psycho-social and cultural interventions are recorded • where needs have been identified, there is a record that the service user has been offered a range of bio-psycho-social and cultural interventions • bio-psycho-social and cultural interventions are delivered by appropriately trained and accredited staff who have regular practice supervision as per procedures • there are systems for the provision of interventions including: o delivery within three months of referral o review of individual service user progress o recording outcome

Recording medication decisions	There is a clinical record of individual psychopharmacology medication decisions. • the clinical record shows the decision making process, including when to initiate change, maintain or discontinue psychopharmacology medication

Care Planning Tools

	The service user and whānau are at the centre of recovery care planning, along with the multidisciplinary team and others (including community support and primary care, circle of care and other mental health community networks). The wider care team should have a flexible / permeable structure in the sense that members of the wider networks may be part of the team according to the needs of a specific service user. The keyworker has responsibility for advocating and co- coordinating the close liaison with the members as necessary.
Person-centred and whānau inclusive care	There is a record that the service user and whānau have actively participated in the planning of care and treatment (Mental Health and Addictions Consumer participation policy 1855), and the participation reflects personal values and beliefs, cultural choices and partnership and the following recovery principles: o hope o personal responsibility o personal meaning o self-advocacy / choice o support o education • the clinical record shows that care is planned and agreed with the service user and/or whānau (Mental Health and Addictions Family / Whānau inclusive practice procedure 5795) in a format that is accessible, at critical points of care e.g. discharge there is evidence of partnership with family whanau. • the clinical record shows that advice has been provided to the service user, their family whānau and/or carer on sources of further information and support, (e.g. voluntary organisations and advocacy services) Whānau should have the opportunity to be involved in decisions about care and treatment (Mental Health and Addictions Family / Whānau inclusive practice procedure 5795).
Recovery plan	The recovery action plan that operates across all service care providers. o the recovery plan records a named key worker o is based on the assessment of needs, strengths and past experience o identifies goals and aspirations o specific tasks treatment and interventions (including social indicators and risk management) o records roles and responsibilities of all individuals and agencies involved o includes a record of service user perspective (including wellness statement if appropriate) o identifies early warning signs / triggers o current medication/s and objectives

- records that service users are invited to hold a copy of the recovery plan
- records unmet needs since the last assessment

The single recovery plan is reviewed regularly (i.e., reviewed at least every 91 days in the community setting and daily in the inpatient setting or earlier dependent on recovery plan objectives):

- service user perspective
- strengths
- whānau perspective
- risk behaviours, events and patterns
- psycho-education
- cultural intervention
- medical / co-existing disorders
- psychology therapies and/or interventions
- vocational rehabilitation
- current medications and changes
- recovery transition progress

Multi-disciplinary team approach	Systems are in place to ensure a multi-disciplinary service delivery that ensures that all bio-psycho-social and cultural components of intervention and care are delivered. • there are systems to ensure that service users are assessed and managed by a multidisciplinary team • the team will enable the following functions to be available to service users: o continued proactive care of those with mental health problems o access to information, and intervention / treatment before and during crisis • there are systems allowing service users to access appropriate services (e.g., when a referral is made, a record of all relevant assessments must be included with the referral documentation) • systems are in place to involve multi-agencies (including, general practitioner, advocacy services and voluntary organisations) in the care of service users Multi-disciplinary team working enables the provision of a wide range of specialty inputs and resources for service users and to provide a seamless service to service users' which enhances continuity of care. o within teams o across inpatient and community o across services o and, external agencies While verbal communication is central to all aspects of multi-disciplinary team functioning, discussion must be recorded. Team conflict will be resolved through communication.

Bio-psycho-social and Cultural Interventions

	At the heart of Mental Health and Addictions service delivery and care is a varied selection of bio-psycho-social interventions and treatment preferences. These interventions or treatments define the capabilities and competences required by health practitioners and professionals. These are the skills that will be evidence in their practice and work with an individual service user. Health practitioners' expertise may vary according to their experience, their qualifications and the work involved in obtaining their qualifications.
Bio-psycho-social and cultural interventions	Care is delivered within the person-centred, culturally responsive, recovery focused, bio-psychosocial-whānau inclusive approach to interventions: • there are systems in place to deliver bio-psycho-social and culturally appropriate care through the integrated care pathway • appropriate processes to support prospective planning of the bio- psycho-social and cultural care inputs
Workforce development	Workforce development needs are identified and acted upon. • there are systems to ensure that the training and supervision needs of staff are acted upon • training and supervision needs are incorporated into the organisation's workforce development plans • each profession maintain their own professional skills and will bring to their work the skills associated with their discipline or professional group

7 Audit Indicators

	Mental Health and Addictions service support recovery driven care, and seek to monitor and measure changes in service user's health, wellbeing and circumstances overtime. Measuring outcomes for service users using services supports the best possible service delivery and understanding of effective service delivery. Using outcome and audit information appropriately ensures a recovery focus and supports continuous quality improvement and innovation.
Timeliness	There are systems in place to measure compliance with the care interaction tasks timeframe which affect progressive service user integrated care pathway flow through service: • service wide systems are in place to monitor and plan service delivery demand and capacity • systems in place for the multi-disciplinary team to prospectively plan and schedule individual service user care along the pathway interaction tasks
Measure of needs and outcome	A professionally rated validated tool is used to measure service user need and outcome: • the clinical record includes a needs assessment scale which is rated by service users and whānau (e.g., HoNOS, ADOM) • the clinical record includes a professionally rated assessment tool (e.g., HoNOS, ADOM) which is validated for the relevant service user group to monitor outcome
Service improvement	The information gathered through regular review of integrated care pathways and from analysis of variance leads to continuous improvement of practice and service change:
Success indicators	Mental Health and Addictions meets the reporting requirements and complies with national, regional and service determined key performance indicators: • there is an agreed decision-making quality framework to support the identification of key performance, flow and variation indicators of recovery care • there are systems in place to monitor, report and action the quality of care on a regular basis (i.e., quality framework)

8 Legislative requirements

Waikato DHB Mental Health and Addictions service is required to meet and comply with the following legislation (this list is not exclusive):

- Alcoholism and Drug Addiction Act 1966
- Code of Health and Disability Services Consumers' Rights Act 1994
- Crimes Act 1961
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Health and Disability Sector Standards NZS8134:2008
- Health and Disability Consumer Rights Act 1994
- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003
- Land Transport Act 1998
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998
- Misuse of Drugs 1975 – section 24
- Protection of Personal and Property Rights Act 1988
- Victims' Rights Act 2002
- Health and Safety in Employment Act 1992
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1992

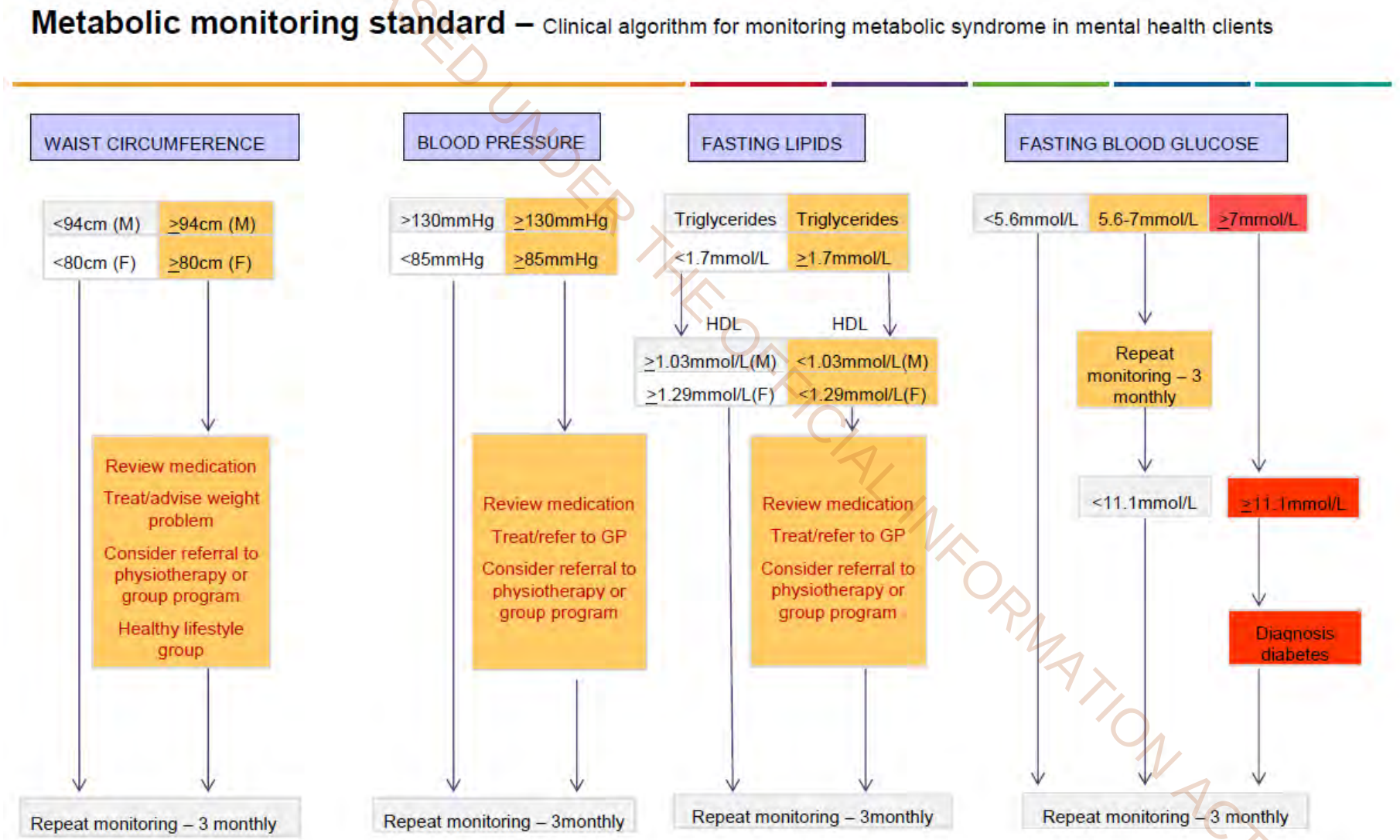
9 Associated Waikato DHB Documents

This policy should be read in conjunction with the following:

- Waikato DHB incident management policy (0104)
- Waikato DHB managing behavior and performance (5250)
- Waikato DHB Violence Intervention Programme – Intimate Partner Violence (2202)
- Waikato DHB Violence Intervention Programme – Child Protection (1809)
- Waikato DHB Violence Intervention Programme – Vulnerable and Older Adult Protection (3025)
- Waikato DHB employee information policy (1775)
- Waikato DHB interpreters and translation policy (0137)
- Waikato DHB informed consent policy (1969)
- Waikato DBH suicidal or deliberate self-harm thoughts or behaviour, management of patients policy (1811)
- Waikato DHB tikanga best practice guidelines
- Waikato DHB Information Privacy Policy (1976)
- Mental Health and Addictions advance directives procedure (2181)

- Mental Health and Addictions appointment planning and the management of DNA's with service users / tāngata whaiora (0900)
- Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others procedure (5241)
- Mental Health key worker procedure (1558)
- Mental Health consumer participation policy (1855)
- Mental Health and Addictions Family / Whānau inclusive Practice (5795)
- Waikato DHB Ethnicity Data Collection Policy (0100)

Appendix A, Metabolic monitoring standard



Keyworker

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Nicola Livingston
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
04	Nicola Livingston	October 2022	Changed to Te Whatu Ora Waikato template and change of language from Waikato DHB to Te Whatu Ora throughout document Full document review Inclusion in 2.4 of statement about allocation of keyworker Consistent spelling of tāngata whaiora and whānau
03	Lynette Eade	August 2017	Addition of family / whānau as part of the client group. roles and responsibilities The process of mapping and clearly outlining of all interventions and clear identification of what, who and when the interventions will be completed.

Keyworker

Contents

Keyworker

1 Overview

1.1 Purpose

This document sets out the role of the keyworker; the principal activities associated with key working and the keyworker allocation process required to meet the needs of tāngata whaiora and whānau.

1.2 Scope

Key working is a primary component of the role of designated registered health professionals / health practitioners working within clinical teams who have a central role in the oversight, development, coordination, implementation and review of tāngata whaiora treatment care / risk / recovery / relapse prevention plans in partnership with tanagat whaiora and whānau.

Keyworkers in community teams have a pivotal leadership role in managing, but not necessarily providing, all aspects of a tāngata whaiora care through the various phases of their illness and recovery journey. This includes the effective coordination, continuity, integration and communication of all care delivered by other services during certain phases of intervention.

Keyworkers work within their discipline and specific scope of practice integrating key working skills alongside those developed within their professional, clinical, education and experience. Additionally, keyworking skills will be delivered within the framework of a recovery oriented service and with due reference to usual clinical policies, procedures, guidelines and statutory requirements.

1.3 Patient / client group

Tāngata whaiora and whānau of the Mental Health and Addictions service.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

Advocacy	Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to: • Have their voices heard on issues that are important to them. • Defend and safeguard people's rights. • Access information and services on person's behalf. • Explore choices and options
Allocation	The process of assigning a keyworker to tangata whaiora.
Coordination of Care	A collaborative process that promotes quality care, continuity of care and effective outcomes which enhance the physical, psychosocial and vocational health of individuals. It includes assessing, planning, implementing,

	coordinating, monitoring and evaluating health and social care related service options across health and social care providers.
Keyworker	A registered health professional / health practitioner or social worker eligible for registration. He / she coordinates (but does not necessarily provide) all care for the tāngata whaiora, including external agency input. He / she is responsible for coordinating the treatment care/ recovery / relapse prevention planning process, including discharge planning, and documentation. He / she is the primary point of contact, within Te Whatu Ora Waikato, for tāngata whaiora and whānau and other service providers working with a tāngata whaiora.
Multi-disciplinary team	A group of registered health professionals / health practitioners who work together to determine goals, evaluate outcomes, and make recommendations and deliver holistic interventions and treatment to assist in the service user recovery at a particular point in time.

2 Clinical management

2.1 Roles and responsibilities

Keyworker

The functional responsibilities for a keyworker include:

- Facilitating the journey of tāngata whaiora through the integrated care pathway and acting as the first point of contact for the tāngata whaiora, whānau and other carers
- Working collaboratively with tāngata whaiora and their whānau in an inclusive, strengths based and recovery focus
- Acting as a communication resource and co-ordinator for other members of the multi-disciplinary team, services or agencies involved in the delivery of care
- Fostering an environment of continuity of care and managing transitions of care through the integrated care pathway within planned timeframes
- Ensuring appropriate knowledge and links with Mental Health and Addictions service, primary care services and other agencies to guide and inform tāngata whaiora and whanau.

Charge Nurse Manager / Team Leader

- Monitor the process of allocation to keyworkers to ensure appropriate management of caseloads based on workload, acuity and experience
- Monitor the movement of tāngata whaiora across the integrated care pathway
- Monitor the key performance indicators.

Multi-disciplinary team members

- Collaborate with keyworker to ensure discipline specific interventions are included in the plan of care for the tāngata whaiora (occupational therapy, social work, psychology, registered nursing, medical)
- Discuss with medical staff at the multidisciplinary meeting any needs that require senior medical staff intervention.

2.2 Competency required

- A registered health professional / health practitioner or social worker eligible for registration.
- Staff will have completed the Mental Health and Addictions service orientation to their role and relevant mental health and addictions service education as defined with their line manager within a designated time period.

2.3 Equipment

- Mobile phone
- Vehicle access
- Information Systems inclusive of and not limited to:
  - Access to Clinical Workstation
  - Community Dashboard
  - Flinders Board

2.4 Procedure

- Tāngata whaiora is accepted into Mental Health and Addictions Service
- Discussion will occur within the MDT as to the identified presenting needs of tāngata \whaiora. Once it is confirmed that a keyworker is required, the MDT will identify who is the most appropriate clinician to be the keyworker. This decision should take into consideration matching of clinician to the tāngata whaiora in terms of skill, discipline-specific strengths, gender and cultural considerations.
- Keyworker is allocated and detailed on iPM
- The Mental Health and Addictions Integrated Care Pathway Policy (1703) provides the overview of the pathway. Specifically, the keyworker is responsible for advocacy and coordination of care, ensuring the timeframes and movement of the tāngata whaiora across the pathway.

Keyworker

Pathway component	Keyworker task
Initial engagement and transfer of care planning	• Introduce self and service to tāngata whaiora and whānau, and outline role as a keyworker, including their role as first point of contact. • If whānau are not present, discuss with tāngata whaiora about including whānau – identify who they are, what role they will play, what information can be shared with them • Gather information from the tāngata whaiora and whānau including goals, aspirations, strengths • Provide verbal and written information to tāngata whaiora and whānau on roles, responsibilities, the integrated care pathway, and education and support opportunities, including peer support services and whānau support services. • The mapping of requirements for transfer of care back to the Community / Primary Care is to begin from the entry phase into the service.
Assessment	• Complete a holistic and / or cultural assessment of health and social care. This will include gathering information from various sources (including whanau, carers, primary care, NGO's, government agencies etc.). The assessment process will inform: - recovery / relapse prevention planning - risk assessment - and diagnosis in collaboration with the multidisciplinary team • Formulation and management of the risk process using the Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others and child protection and Te Whatu Ora vulnerable person's policies and guidelines. • Whānau / carers needs will be considered and recorded, but any actions / outcomes must always be in the tāngata whaoira best interests. Where there are conflicting needs and /or a lack of agreement between tāngata whaiora and whānau, advice from the multidisciplinary team should be sought. • Whānau will be offered a referral to an NGO for their own support and education. • HoNOS rating should be completed at the time of assessment every 90 days thereafter. • HoNOS completed on admission from community to inpatient / inpatient to community. • Social Indicators are to be completed as per the service requirements.
Planning	• Identifies the goals, aspirations and strengths of tāngata whaiora, and interventions required to support tāngata whaiora journey through the integrated care pathway. This includes

	identifying relevant members of the multidisciplinary team and appropriate external agencies to enact the interventions internally and externally. This also identifies the role of whānau in supporting tāngata whaiora journey. • All tāngata whaiora must be offered a recovery plan in an accessible and understandable language and format in accordance with the procedures and standards outlined below. The recovery plan will be in plain language and in the words of the tāngata whaiora. • Recovery care planning should be completed in collaboration with tāngata whaiora and their whānau. Recovery planning should be personalised and meaningful, putting the tāngata whaiora at the centre of the process. An holistic approach will have a positive impact on wellbeing and will support tāngata whaiora to make informed decisions regarding their care. • Recovery care plans should reflect both immediate and long term goals and will identify how and when they are achieved, and by whom. • The Keyworker has an important role in working with tāngata whaiora and whānau to identify stressors and/or early warning signs and identify strategies / put plans in place to manage and reduce risk. • The recovery care plan will outline the way in which tāngata whaiora, whānau, keyworker, clinicians and / or external agencies (where indicated) will work together to reach and maintain tāngata whaiora best possible level of comfort, dignity and wellbeing.
Interventions	• The keyworker will have oversight of and coordinate, not necessarily provide, the interventions to ensure that the recovery plan is meeting the needs of tāngata whaiora. • With consent of tāngata whaiora, interventions should include whanau. • Where the tāngata whaiora does not give consent for whānau to be included, the keyworker will explore, on an ongoing basis, the reasons tāngata whaiora does not want whānau involved, and will discuss the value whānau involvement can have on their journey. • If tāngata whaiora mental health deteriorates or there is a change in risk presentation, a review of the provision of care is to be completed immediately including a face to face review with tāngata whaiora and consultation with whānau / other services / clinicians involved in care. • Appointment planning supports and enables engagement. This includes discussing how follow-up / interventions will occur, including the frequency of contact, whether contact is face to face, phone or virtual and time of day planned follow-up / appointments will occur. How appointment reminders occur will also be agreed upon.

	• If the tāngata whaiora is transferred to the inpatient service / home based treatment / respite service the keyworker continues with their networking and advocacy role to ensure goal attainment based on current tāngata whaiora needs. The keyworker plays a key role in actively engaging with the inpatient recovery journey and linking this with the community pathway for the tāngata whaiora. • When tāngata whaiora transfer from an episode of inpatient care to the community the keyworker will follow-up within 7 days, ideally within 3-4 days to support safe and effective transition to the community, then weekly for a further 3-4 weeks based on clinical need, discussion with tāngata whaiora / whānau and discussion in MDT Follow-up will be face to face as much as possible. • When tāngata whaiora experience a crisis episode, the keyworker will increase the frequency of follow-up, seeing tāngata whaiora / whānau face to face as frequently as necessary, in discussion with tāngata whaiora / whānau/ MDT to facilitate their recovery, prevent a relapse and manage risk. Frequency of ongoing follow-up should be discussed with tāngata whaiora and whānau, agreed upon, discussed in MDT and documented in CWS • Keyworking responsibilities can be allocated to another named clinician at any point during an episode of care, with the agreement of the new Keyworker and following discussion with the tāngata whaiora and team manager. The reallocation and responsibilities may be for a short period of time due to absence of the Keyworker or as a planned transfer in Keyworker role. At all times the tāngata whaiora and whānau is to be aware of who is acting as their Keyworker. • The keyworker handing responsibilities over should give a verbal handover of clinical information and ensure all documentation is updated including recovery plan, risk assessment, HoNOS and clinical notes. Where possible, the keyworker will introduce the new keyworker to the tāngata whaiora and whānau as part of the process
Review	• The Keyworker meets with the tāngata whaiora and whānau / support person regularly based on recovery plan timeframes. The Keyworker will ensure the planned interventions are progressing and are reviewed with the assigned clinician and / or external agency to ensure the current needs and goals of the tāngata whaiora are being met. The map of interventions identified from the recovery plan is to be evaluated and updated. Any barriers to achieving recovery aspiration will be advocated through coordination and negotiation by the Keyworker. The Keyworker needs to ensure that interventions are being provided: - at the right time - by the right person - in the right place

	- in the right way • Organise multidisciplinary team review with the appropriate members of the team. • Ensure that there is a review with tāngata whaiora and their whānau planned every 90 days at a minimum or sooner if there is a change in circumstances. The recovery plan is to be utilised within the community pathway and links with any acute care goals for an acute intervention phase within this pathway. • Reformulate the goals and planned interventions if the tāngata whaiora requires this or progress to the Transfer of Care phase if the tāngata whaiora has met the goals and is ready for transfer to primary healthcare. • Reassess the assessment phase as this is a continuous process and information recorded at the initial assessment must be reviewed and updated.
Transfer of Care	• By the time the transfer of care to primary care is to be undertaken all required tasks for transfer must be completed inclusive of all supports for the tāngata whaiora and their whānau. • This includes liaison with the General Practitioner and any other relevant external supports ie non-government organisations. • Complete transfer of care documentation in accordance with transfer of care processes

3 Patient information

- Written information is provided to the tāngata whaiora outlining responsibilities, expectations of the service and contact information of their keyworker (look at letter to be given)
- Information is also provided to the whānau as to the above and information about support and education available for whānau.

4 Audit

4.1 Indicators

- Quality audit process

4.2 Tools

- Key Performance Indicators

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health Integrated Care Pathway policy (1703)
- Mental Health Family Whānau Inclusive Practice guideline (0896)
- Risk: The assessment and management of service users at risk of harm to self or others procedure (5241)
- Te Whatu Ora vulnerable person's policies and guidelines

5.2 Legislation

twow Mental Health and Addictions service is required to meet and comply with the following legislation (this list is not exclusive):

- Alcoholism and Drug Addiction Act 1966
- Code of Health and Disability Services Consumers' Rights Act 1994
- Crimes Act 1961
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Employment Relations Act 2000
- Health and Disability Sector Standards NZS8134:2008
- Health and Disability Consumer Rights Act 1994
- Health and Safety at Work Act 2015
- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003
- Land Transport Act 1998
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998
- Misuse of Drugs 1975 – section 24
- Privacy Act 2020
- Protection of Personal and Property Rights Act 1988
- Treaty of Waitangi Act 1975
- Victims' Rights Act 2002

Leave – Adult Mental Health Inpatient Wards and OPR1

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions staff working in adult inpatient wards
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
05	Working Group	August 2017	Reviewed escorted and unescorted leave requirements and documentation for leave
06	Kylie Balzer	April 2020	Increased emphasis on planning leave and involvement of family / whānau and carers
07	Kylie Balzer	October 2023	Key support persons added Updated into current template for procedures Updates include OPR1

Leave – Adult Mental Health Inpatient Wards and OPR1

Contents

Leave – Adult Mental Health Inpatient Wards and OPR1

1 Overview

1.1 Purpose

This procedure outlines the process to be followed when making decisions about and facilitating leave for tāngata whaiora in adult inpatient wards.

Decisions about leave from adult and OPR1 inpatient wards must consider the rights of tāngata whaiora, their recovery goals and the anticipated benefits of leave. Leave is a planned clinical intervention used to facilitate safe transition into the community prior to discharge.

This leave procedure is applicable to leave provision for both informal tāngata whaiora and tāngata whaiora currently subject to the requirements of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Escorted Leaves must not be used to facilitate smoking or vaping.

1.2 Staff group

Mental Health and Addictions staff working in the adult and OPR1 mental health inpatient wards.

1.3 Patient / client group

This document applies to all inpatients of the adult and OPR1 mental health wards.

1.4 Exceptions / contraindications

Tāngata whaiora on any level of observation who need to attend a clinical appointment at Waikato Hospital are exempt from this procedure. A clinical rationale for the need for attendance at the clinical appointment versus the risk is to be discussed and documented in the clinical record by the medical team in this instance.

1.5 Definitions and acronyms

Informal	Tāngata whaiora who are inpatients on a voluntary basis, not admitted under the mental health act, and not legally obliged to be on the unit.
Leave authorisation plan	Plan defining tāngata whaiora individual risk and leave category
Leave record	Document used to sign tāngata whaiora in and out of the ward
Responsible adult	A person deemed as capable, by a registered clinician of taking responsibility for the tāngata whaiora during a period of leave.

2 Clinical management

2.1 Roles and responsibilities

SMO responsibility

SMO's are responsible for approving the tāngata whaiora leave category in accordance with their current assessed level of risk. They are also required to ensure the leave authorisation plan is completed as a priority.

The multidisciplinary team should be involved in leave discussions.

Tāngata whaiora designated registered health professional on a shift

The designated registered health professional on a shift is responsible for the oversight of tāngata whaiora leave processes during their shift.

Ensure that the Next of Kin details on the registration of the clinical workstation are up to date as part of the leave planning process.

All staff

All staff working in the adult and OPR1 inpatient wards must be familiar with the leave procedure and the required processes and responsibilities.

Managers

Charge Nurse Managers are to ensure all staff receive information on the leave procedure as part of their orientation to the ward.

Any deviations from the required leave processes are to be discussed with individual staff and a process put in place to ensure the procedure can be implemented as required.

Administration Staff

Administration staff are responsible for uploading leave monitoring forms into the clinical workstation every weekday morning, and on a Monday for the weekend period.

Ensure that Next of Kin details on the registration page of the clinical workstation are updated as advised by the registered health professional.

2.2 Competency required

All staff are to be competent in their assigned responsibilities as a component of the application of the leave process.

2.3 Equipment

- Clinical Workstation (CWS)
- Electronic whiteboard
- Leave authorisation and management plan
- Leave plan
- Relevant mental health act leave forms
- Equipment for the tāngata whaiora to identify the time whilst out on leave e.g. watch
- Leave record
- Radio transmitter / ward cell phone (for staff escorting)

2.4 Procedure

Leave for informal tāngata whaiora

While informal tāngata whaiora can leave the ward at any time, it is reasonable to ask them to remain in the ward for up to a period of 72 hours prior to being granted leave. This allows the clinical staff a period of time to review their mental state and level of risk.

If an informal client does not agree to remain on the ward for the 72 hour period the responsible clinician or delegate must be notified and a discussion held around current mental state and level of risk. If there are significant concerns for the tāngata whaiora safety or the safety of others it should be considered if the criteria for the Mental Health Act are satisfied to make an assessment, or whether it is more suitable for the tāngata whaiora to be cared for by a service within the community.

On admission the informal tāngata whaiora are informed of their rights in relation to leave, and provided with the information sheet on entry and exit of the wards. This is done as part of the informed consent process on admission. The discussion and provision of this information is to be documented in the clinical record.

Prior to any informal tāngata whaiora leaving the ward the leave monitoring form must be completed as to exit time, and intended return time. The tāngata whaiora is to be aware of the time documented that they are expected back, and have a means of contacting the ward should they be delayed.

Leave for tāngata whaiora under the Mental Health Act

Leave for newly admitted tāngata whaiora

Newly admitted tāngata whaiora under the mental health act are not to be granted leave, even for brief periods, until the treating team have developed enough familiarity with them to make a valid assessment of their mental state and risk. All tāngata whaiora admitted under the mental health act are to be made aware of their rights, and be informed that they will not be granted leave within the initial 5 day assessment period.

Tāngata whaiora requesting leave to smoke should be offered nicotine replacement aids.

Preparing for leave

Discussions about leave should occur in advance whenever possible. Ideally the tāngata whaiora, and responsible whānau / key support person / carers will be involved in discussions about leave.

These discussions should explore the tāngata whaiora views and preferences about leave, the goals and benefits of leave, and any risks, and the responsible whānau / carer's viewpoint and circumstances.

Whānau and carers must have reasonable information about the tāngata whaiora mental state and level of risk to enable them to make an informed decision about participating in the period of leave.

The leave category once identified and documented by the SMO is valid for a one week period, however may be reviewed more frequently if required. It is the responsibility of the treating team to document the duration, frequency of leave and any expectations on the leave plan. A copy of the leave plan is to be provided to the tāngata whaiora; whānau /

carer prior to the leave being undertaken, and this must be documented in the progress notes.

Leave categories	Description
No leave	The tāngata whaiora is not currently permitted leave from the ward.
Escorted leave with a staff member	*Escorted leave* is for the purpose of a defined therapeutic intervention e.g. going to the grocery store, attending an interview at work and income, viewing a property (this is not an exhaustive list). *Escorted leave* should only be approved after the clinical team including the Responsible Clinician have reviewed the person and consulted with the whānau / key support person / carers.
Unescorted leave	May occur on or off hospital grounds, negotiable between the tāngata whaiora and allocated registered nurse or in Ward 41 a registered health professional at ACNM discretion and in accordance with the documented leave plan *Unescorted leave* should be for a therapeutic purpose and not for frequent short breaks.
Overnight(s)	Leave to an agreed upon residence for one or more overnight periods as agreed in the leave plan by the Responsible Clinician

It needs to be recognised that leaving the ward for even brief periods can present the same amount of risk as other types of leave, and requires the same amount of assessment of risk and mental state. If a request is made at short notice for special circumstances a clinician familiar with the tāngata whaiora mental state and risk must discuss this request with the on call psychiatrist and the results of this discussion are documented in the progress notes.

Process for going on leave

Prior to any leave process (escorted, unescorted, overnight) the following key actions must be completed:

- An approved leave plan has been authorised and agreed by the responsible clinician, the tāngata whaiora and whānau / key support person / carer
- A review of the current risk of the tāngata whaiora is completed and documented
- Current mental state is to be assessed and documented in the clinical record immediately prior to the period of leave. Any concerns about leave going ahead need to be discussed with the treating team.

- The tāngata whaiora and whānau / key support person / carer are aware of the expected return time, and this is documented to enable any variance to be immediately noted by ward staff. The recording of leave exit and entry is also documented on the leave monitoring form.
- Whānau / carers accompanying tāngata whaiora on leave are aware of their responsibilities whilst the tāngata whaiora are on leave. Leave is a collaborative process and if the whānau / carers have any concerns then leave should be reconsidered.
- The full name and contact details of the whānau / key support person / carers have any concerns then leave should be reconsidered.
- The full name and contact details of the whānau / key support person / carer are documented in the leave plan
- Provision is made to ensure that the tāngata whaiora has access to any necessary medications / equipment requirements.

Revoking Leave
Any clinician is able to revoke leave due to a change in mental state, risk or demonstrated inability to meet the requirements of leave responsibilities. When revoked the leave authorisation plan must be updated and the SMO / treating team advised. Appropriate communication with the tāngata whaiora of any changes to leave approval is to occur.

The communication of this information must take account of the tāngata whaiora current state and needs upon hearing the news.

Failure to return from leave
Any tāngata whaiora who does not return to the ward within the agreed timeframe is to be categorised and followed up as per the Mental Health and Addictions AWOL (Absent Without Official Leave) procedure (3555).

3 Patient information

Information on leave provision and processes is discussed with tāngata whaiora and whānau.

4 Audit

4.1 Indicators

- All informal tāngata whaiora are provided with an entry and exit information sheet upon admission.
- All tāngata whaiora under the mental health act and whānau / key support persons / carers receive leave plans prior to leave being undertaken.

4.2 Tools

- Audits against the requirements of the Ngā Paerewa Health and Disability services standard

- Compliments and Complaints
- Whānau feedback systems

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions AWOL (Absent Without Official Leave) procedure (3555)
- Mental Health and Addictions Levels of Observation across all Mental Health and addictions inpatient services procedure (5238)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others protocol (5241)
- Mental Health and Addictions Whānau Inclusive Practice guideline (5795)

5.2 External Standards

- Ngā Paerewa Health and Disability Services Standards NZS8134: 2021
- Mental Health (Compulsory Assessment and Treatment) Act 1992

Leave – Puawai Inpatient wards

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions staff working in Puawai inpatient wards
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes

Leave – Puawai Inpatient wards

Contents

Leave – Puawai Inpatient wards

1 Overview

1.1 Purpose

A prolonged period of time spent in prisons or hospitals, can contribute to reduced opportunities for work, education, skill development, and social interactions. This can then result in service users / tāngata whaiora becoming so removed from the roles of community life that they lose the ability to structure their time to meet the challenges of successful community integration.

Leaves are one aspect of rehabilitation that can provide support, and opportunities to connect with the community. Community leaves have the potential to foster a sense of hope for a meaningful life outside of the hospital; they are a necessary and frequent activity involving a process of graduated leaves. The focus of the leaves should progress from basic community skills, e.g. shopping or using public transport, to eventually linking with agencies, and other services in the community.

Community leaves also provide opportunities for service users / tāngata whaiora to interact with people in the community as well as with the escorting staff member. In the context of recovery, leaves should involve activities aimed at hope of a meaningful life, supporting personal responsibility, and becoming more connected.

The escorting staff member's role is important and can have either a positive or a negative effect on the extent to which the leaves are consistent with a recovery model.

Escorted leaves must not be used to facilitate smoking or vaping.

This procedure outlines the process to be followed when identifying and implementing leave for service users / tāngata whaiora in Puawai inpatient wards.

1.2 Scope

This procedure is applicable to the entry, exit, identification and application of leave status within the Puawai inpatient wards.

This document applies to all inpatients of the Puawai wards.

1.3 Patient / client group

Service users / tāngata whaiora who are inpatients in Puawai wards.

1.4 Definitions

Special Patient	The term 'special patient' refers to mentally ill offenders detained under specific legislative provisions.
Exit forms	Weekly forms stating approved leaves and service user / tangata whaiora and staff ratios. All service users / tāngata whaiora on all Puawai wards have exit forms regardless of legislation. Exit forms are used to sign all service users / tāngata whaiora in and out of the Puawai wards.
MOH	Ministry of Health

DAMHS	Director of Area Mental Health Services
SMO	Senior Medical Officer
CNM	Charge Nurse Manager

2 Clinical Management

2.1 Roles and Responsibilities

SMO/CNM responsibility

- Apply for leave categories to MOH and DAMHS as required, providing all relevant documentation.
- Check, approve and sign exit forms on a weekly basis in accordance with legislation.

Multidisciplinary team (MDT) responsibility

- Agree on length of leave and frequency of leave after MOH / DAMHS has approved (if relevant). The actual taking of leave will be dependent on staffing and ward environment at any given point of time.
- Complete exit forms sign in/out sheet for all Service users / tāngata whaiora leaving and returning to the ward.

Registered Nurse

- Record the service user's / tāngata whaiora mental state each morning before taking already approved allocated leaves for that day..

2.2 Competency required

An SMO and the multidisciplinary team (MDT) must be involved in the allocation of, or approval of leave, dependent on legislation and MOH / DAMHS approval.

2.3 Equipment

- Relevant MOH / DAMHS approval documents
- Exit forms
- Clinical Workstation (CWS)
- PFM board
- Relevant mental health act leave forms if person under the mental health act
- Equipment for the service user to be able to identify the time when out on leave e.g. watch. Communication equipment for staff to maintain contact with ward e.g Radio transmitter or ward cell phone

2.4 Procedure

Leave status

All approved leaves are documented on individual exit forms; if the service user / tāngata whaiora has no leaves, or the leaves are on hold for some reason, then this is also recorded on their weekly exit forms. Each approved leave has an allocated time frame attached to it e.g. Up to 30 minutes.

The following leave categories apply to all service users / tāngata whaiora:

No leave
The service user / tāngata whaiora is not permitted leave from the ward
Escorted leave with a staff member
May occur on or off hospital grounds dependent on prior approval, *Escorted leave* is for the purpose of a defined therapeutic or recreational activity / intervention e.g. going to the grocery store, attending an interview at work and income, viewing a property / supported accommodation, attending the gym, clothes shopping etc. Ratios are usually 2:1, 1:1 or 1:3
Unescorted leave
May occur on or off hospital grounds dependent on prior approval, and is negotiable between the service user / tangata whaiora and allocated registered nurse
Overnight(s)
Leave to an agreed upon residence for one or more overnight periods- approved by the Responsible Clinician and MOH / DAHMS where relevant

Leave is a planned clinical intervention used to safely support reintegration into community settings. Leave is allocated in an incremental manner by the multidisciplinary team and after approval by the MOH / DAMHS if the service user is a Special Patient.

The following are the usual incremental steps of allocated leave:

Escorted hospital grounds leave
For the purpose of attending medical appointments, therapeutic programmes or short walks in the grounds
Escorted community leave
For the purpose of social inclusion in a gradual and supportive way Commences with short walks in the neighbourhood vicinity Progresses to local area leave i.e. YMCA gym / lake / Pak n Save Further progression is to Hamilton City Centre (and surrounds) which might include whānau home visits or attendance at specific functions i.e. sports events, cultural activities etc.
Unescorted hospital grounds leave
For the purpose of time management assessment, taking responsibility and establishing trust.

Unescorted community leave
For the purpose of social inclusion and promotion of independence Commences with short walks in the neighbourhood vicinity Progresses to local area leave i.e. YMCA gym /lake / Pak n Save Further progression is to Hamilton City Centre (and surrounds) which might include whānau home visits or attendance at specific functions i.e. sports events, cultural activities etc.
Overnight leaves (unescorted or escorted)
For the purpose of connecting with whānau or transitioning to supported accommodation/ independent living. At times these are escorted for the purpose of tangi/ wedding/whānau illness

Leave decision making is dependent on prior approval which is documented on individual exit forms, the level of service user / tāngata whaiora risk and the current context within the ward. The allocated registered nurse can decline leave due to risk for the service user / tāngata whaiora or to the ward.

Prior to the daily approved leaves being allocated it is critical that there is documentation by an RN that clearly identifies:

- Current mental state
- Current level of risk
- What clothing the service user / tāngata whaiora is wearing

The recording of leave exit and entry time is completed on the exit form

The expected return time is clearly available so that any variance from this can be immediately noted.

Anyone going on overnight leave will have a comprehensive leave management plan detailing purpose of leave, date of leave, emergency and whānau contacts, risk mitigation strategies and early warning signs.

Revocation of leave

Any clinician is able to revoke leave due to change in mental state, risk or demonstrated inability to meet the requirements of leave responsibilities. When revoked, the exit form and handover SBARR must be updated and the SMO / CNM / treating team advised.

If the service user / tāngata whaiora is a Special Patient the DAMHS will be notified

Appropriate communication with the service user / tāngata whaiora of any changes to leave approval is to occur.

Failure to return from leave

Any service user / tāngata whaiora who does not return to the ward within the agreed upon timeframe should be categorised and followed up as per the AWOL (Absent without official leave) procedure (3555).

3 Patient information

Information on leave responsibilities and map of walking routes within hospital campus / local area will be provided.

4 Audit

4.1 Indicators

- All service users / tāngata whaiora and family / whānau/ supported accommodation providers receive leave plans prior to leave.

4.2 Tools

- A documentation review of service users / tāngata whaiora clinical record will show that service users / whānau have received information on their leave plan.

5 Evidence base

5.1 External Standards

- Health and Disability Service Standards NZS8134: 2008
- Mental health (Compulsory Assessment and Treatment) Act 1992

5.2 Associated Waikato DHB Documents

- Mental Health and Addictions AWOL (Absent Without Official Leave) or Absences Causing Concern procedure (Ref. 3555)
- Mental Health and Addictions Family / Whānau Inclusive Practice guideline (Ref. 5795)

Levels of Observation across all Mental Health and Addiction Inpatient Services

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addiction Services
Document Facilitator Name	Carole Kennedy
Document Facilitator Title	Nurse Director
Document Owner Name	Rees Tapsell
Document Owner Title	Director of Clinical Services
Target Audience	Mental Health Inpatient Staff
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
06	Carole Kennedy	12/08/2016	Updating the procedure. Clear definitions Focus on therapeutic engagement – moved to e learning Clear exception criteria
07	Carole Kennedy & Sarah Taylor	27/06/2020	Included establishing therapeutic engagement Observation forms updated
	Kylie Balzer	14/01/2024	Procedure extended for one year

Levels of Observation across all Mental Health and Addiction Inpatient Services

Contents

Levels of Observation across all Mental Health and Addiction Inpatient Services

1 Overview

1.1 Purpose

This procedure provides a framework to inform the appropriate levels of observation for tāngata whaiora whilst an inpatient in our care. An assigned level of observation monitors safety and is incorporated into the tāngata whaiora plan.

1.2 Scope

This procedure applies to all clinical staff working across Adult Inpatient, Puawai and OPR1 and can still apply to any tāngata whaiora transferred to the General Hospital under the Mental Health Act. (Management of mental health service users in Waikato Hospital 5438). This procedure provides a framework to ensure clinical safety and effective outcomes for tāngata whaiora in our inpatient settings.

Levels of observation relates to mental health status monitoring and physical health monitoring is to be done in accordance with other DHB procedures. The least intrusive monitoring is to be undertaken whilst maintaining tāngata whaiora safety and dignity.

This procedure also outlines the administration role in ensuring that levels of observation documents are available in the clinical workstation.

1.3 Establishing therapeutic engagement

Engagement and observation is about enhanced needs being met, it must be recognised that observation is only one aspect of caring for people with a high level of distress. All staff are expected to engage with tāngata whaiora in meaningful activities and providing psychological support, applying the principles of sensory modulation.

It is clearly not enough to simply observe people. The process must be both safe and supportive. People who need this level of help are going through a temporary period of increased need. Whatever the cause, they need at that moment, safety, compassion, caring and understanding and appropriate treatment. Therefore, tāngata whaiora must also be engaged in a positive and therapeutic relationship both during and after an increased period of need. (Taylor, S. A. (2019) Levels of observations and therapeutic engagement in an adult inpatient mental health service).

1.4 Person centred care / client group

Applies to all tāngata whaiora receiving inpatient care.

Youth presenting for admission awaiting transfer to Specialist inpatient service at Starship require high risk observations or higher as appropriate.

1.5 Exceptions / contra-indications

Informal tāngata whaiora can only be monitored on hourly observations. Any increase in observations would be considered a breach of the tāngata whaiora informal status.

Student Nurses can work alongside their registered nurse preceptor to observe the process and monitoring of level of observations. Occupational therapist students are supported by an occupational student supervisor. Social worker students are supported by placement mentors, however under no circumstances nursing or allied students can carry out the level of observations, on their own.

Whānau/friends can visit but must not be left to provide the observations; a staff member needs to present at all times for high risk and extreme high risk observations.

Tāngata whaiora are assigned transitional level observations when they are considered to be minimal risk to themselves or others whilst residing in the Puna Whiti rehabilitation unit.

Level of observations cannot be utilised for the sole purpose of falls prevention, refer to the falls risk assessment, minimisation and management policy 1705.

1.6 Levels of Observation - Definitions:

Levels of observation	Refer to the intensity and frequency of nurse monitoring and are based on the mental status of tāngata whaiora and risk to self or others
Minimal risk – transitional level of observations	Tāngata whaiora considered to be minimal risk to themselves or others Tāngata whaiora residing in Puna Whiti rehabilitation unit are monitored on transitional levels of observations
Low risk - Hourly Observation minimum level assigned to inpatients	Tāngata whaiora considered low risk must be monitored at irregular intervals of up to 60 minutes apart.
Significant risk - 10 minute Observation	Tāngata whaiora whom require more frequent monitoring must be monitored at irregular intervals of up to 10 minutes. Tāngata whaiora being cared for in wards 36 and Puna Maatai are monitored on a minimum of significant levels of observations
High Risk - Within eye sight and arms reach to be able to respond	For tāngata whaiora who are requiring on-going observations. The designated staff member is able to respond immediately to any changes of at risk behaviour to safely mitigate any harm from occurring.
Extreme High Risk – Same room and within arm's reach at all times	For tāngata whaiora who are considered extremely high risk and who may require immediate intervention.

2 Clinical Management

2.1 Roles and Responsibilities

SMO responsibilities

SMO's are responsible for assessing and reviewing tāngata whaiora level of observations in accordance with their current assessed level of risk.

SMO's are required to review tāngata whaiora whom are on high risk or extreme high risk observations daily at a minimum; inclusive of after-hours.

The multidisciplinary team must be involved in level of observation discussions.

Service user / tāngata whaiora designated registered nurse on a shift

The designated registered nurse on a shift is responsible for the oversight of a tāngata whaiora level of observations during their shift.

The designated registered nurse on a shift is responsible for directing and delegating to enrolled nurses and/or psychiatric assistants to undertake levels of observations.

The designated registered nurse must complete at least one hour over the shift of High Risk Observations or Extreme High Risk Observations to ensure that they can effectively provide nursing assessment, care planning, intervention and evaluation.

At all times the registered nurse must consider the level of expertise, information, and knowledge required by the person completing the levels of observation and provide appropriate information and ongoing guidance.

All staff

All staff working across the inpatient wards must be familiar with the 'levels of observation across all mental health and addiction inpatient services procedure' and the required processes and responsibilities.

All staff are aware that an increase of observations must always be considered following any change of the tāngata whaiora behaviour, circumstances and or transition point.

To complete Levels of Observation – eLearning module Waikato DHB.

Managers

Charge Nurse Managers/Unit Managers are to ensure all staff receive information on the level of observations procedure as part of their orientation to the ward.

Any deviations from the required levels of observation processes are to be discussed with individual staff and a process put in place to ensure the procedure can be implemented as required.

Administration staff

Administration staff are responsible for uploading levels of observation monitoring forms into the clinical workstation every weekday morning, and on a Monday for the weekend period.

2.2 Competency required

All staff are to be competent in their assigned responsibilities as a component of the application of the levels of observation process.

2.3 Equipment

- Clinical Workstation (CWS)
- Electronic whiteboard
- Relevant levels of observation monitoring form

2.4 Procedure

Levels of observation is a clinical intervention put in place to provide additional support and oversight to tāngata whaiora presenting with a change in clinical presentation and risk. Levels of observations are put in place at point of admission throughout their inpatient stay, to mitigate the risk when a tāngata whaiora presentation is escalating, and they are unable to be safely managed on a lower level of observations.

Newly admitted tāngata whaiora will be assessed at the time of admission; the treating team will then determine the appropriate levels of observation based on clinical presentation and risk factors at the time.

At all times there must be a focus on engagement with tāngata whaiora and whānau in the care delivery process. The level of observation, assessment and evaluation is clearly documented within the tangata whaiora clinical documents.

Process for initiating level of observations

All tāngata whaiora are on a specified level of observation. From the time of admission the following key actions must be completed:

- Initiation of the appropriate level of observations monitoring form completed
- Levels of observation is placed on the PFM board
- Levels of observation clearly documented in the progress notes

Increasing levels of observation

Levels of observation may change during a tāngata whaiora admission.

If staff have concerns around changes to a tāngata whaiora clinical presentation and/or risk then this must be escalated immediately and the current levels of observation reviewed and increased accordingly.

Levels of observation can be increased by any clinician at any time based on a clinical assessment. If a decision is made to increase level of observations the following must be completed:

- The appropriate staffing is sourced immediately to support the increased observations

- The designated registered nurse on a shift is made aware of the escalating concerns, if not already involved in the process
- The treating team are made aware of the escalating concerns and arrange to review the tāngata whaiora
- The appropriate level of observations monitoring form is initiated
- Level of observations is updated on the PFM board
- Level of observations and a clear rationale for the increase in observations is documented in progress notes
- Key support person / whānau are informed of the increase in level of observations and the rationale for same
- The tangata whaiora is informed of the rationale for the changes in their level of observations.

Reduction of Levels of Observation

- Tāngata whaiora on Significant, High and Extreme High Risk observations must be reviewed, at least daily by the treating team, or on call medical officer's after-hours. The purpose of the review is to assess the tāngata whaiora mental state and level of risk to ensure that the appropriate levels of observation remains in place.
- If on review it is deemed that the tāngata whaiora levels of observation can be decreased, due to an improvement and change in mental state and risk then the following must be completed:
- For tāngata whaiora on High and Extreme High Risk observations the monitoring form must be signed off by the:
  - A Senior Medical Officer
  - A Senior Nurse, and
  - Designated registered nurse
- For tāngata whaiora on significant observations the monitoring form must be signed off by:
  - A senior nurse and
  - Designated registered nurse
- Levels of observation is updated on the PFM board
- Levels of observation and a clear rationale for the decrease in observations is documented in the progress note
- Key support person/whānau are informed of the decrease in levels of observation and the rationale for same, if appropriate

Multiple levels of observations monitoring

Tāngata whaiora being cared for in wards 36 and Puna Maatai are monitored on a minimum of significant levels of observations. Within these wards levels of observation are captured on the multiple significant observations monitoring form.

Tāngata whaiora cared for in all other wards are generally monitored on hourly observations, unless the clinical needs determines a higher level observation, which would be monitored on individual level of observation forms. All clients on hourly observations are monitored on the multiple hourly observation form.

The senior nurse or delegate is responsible for checking the multiple significant observations and hourly observations form at the end of each shift, to ensure that these have been accurately recorded.

Monitoring of low and significant risk observations must occur at irregular intervals and be documented at the actual time they are completed.

The senior nurse or delegate must sign on the front of the multiple observations record to confirm the form has been completed as per procedure.

3 Patient Information

Levels of observation provision and process is discussed with tāngata whaiora and their key support person / whānau.

4 Audit

4.5 Indicators

- All tāngata whaiora have levels of observation identified and documented in clinical workstation and on the PFM boards – monthly auditing cycle.
- All tāngata whaiora whom present with escalating concerns are assessed and level of observations reviewed aligned with this procedure. Monthly auditing cycle.
- CNM holds a data base of all staff who have completed the eLearning levels of observation on Ko Awatea.

5 Evidence Base

5.1 Associated Documents

- Waikato DHB Clinical Handover, Mental Health Inpatient Wards procedure (Ref. 0451)
- Waikato DHB Direction and Delegation of Enrolled Nurses procedure (Ref. 3003)
- Waikato DHB Fall Risk Assessment, Minimisation And Management policy (Ref. 1705)
- Waikato DHB Nursing Assessment, care planning, Intervention and Evaluation policy (Ref. 5285)

- Waikato DHB Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure:(Ref. 5241)
- Risk Assessment + Pattern Analysis – MH Services (CWS)
- Hourly Observation Record (A1848MHF)
- Multiple Significant Risk Observation Record (T1058MHF)
- Significant Risk Observation Record (T1275MHF)
- High Risk Observation Record (T1572MHF)
- Extreme High Risk Observation Record (T1070MHF)
- Extreme High Risk or High Risk Observations Record continuation sheet (T1056M HF)

5.2 Bibliography

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Standards N.Z. (2008). Health and Disability Services Standards. Wellington: Author.
- Nursing Council of New Zealand (May 2011). Guideline: delegation of care by a registered nurse to a health care assistant. Wellington: Author
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- Enhanced engagement and observation: a paper to inform the development of engagement and observation policies and procedures in inpatient units- New Zealand Directors of Mental Health Nursing, May 2015 (can be found on the Mental Health intranet pages)
- Level of observations and therapeutic engagement in an adult inpatient mental health service. A dissertation submitted in fulfilment of the requirements for the degree of Bachelor of Nursing with Honours, The University of Auckland, 2019. Sarah Anne Taylor https://cdm20076.contentdm.oclc.org/digital/collection/Repository/id/27/rec/1 (view in chrome browser.)

Management of Mental Health Service Users / Tāngata Whaiora in Waikato Hospital

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager Forensic and Acute Adult Mental Health
Document Owner Name	Christine Lowry
Document Owner Title	Executive Director Hospital and Community Services
Target Audience	Clinical staff and managers across Waikato Hospital service and Mental Health and Addictions service
Authorised By	Board of Clinical Governance Lite
Date Authorised	1 March 2021
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
02	Kylie Balzer	April 2020	Updated into current DHB procedure template, and inclusion of responsibilities in line with the Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services.

Management of Mental Health Service Users / Tāngata Whaiora in Waikato Hospital

Contents

1 Overview

1.1 Purpose

This procedure is underpinned by the Waikato DHB Admission, Discharge and Transfer policy (1848) and supports the Waikato District Health Board's (Waikato DHB's) standards for the management of mental health service users / tāngata whaiora in Waikato Hospital. The procedure is intended to provide clear direction in the management of known mental health service users / tāngata whaiora and those presenting at Waikato Hospital that are under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

1.2 Scope

This procedure is applicable to all clinical staff and managers across the Waikato Hospital service and Mental Health and Addictions service (MH&AS).

This procedure specifically details the role of the Mental Health bureau in the provision and oversight of 'specials' that monitor service users / tāngata whaiora under the Mental Health Act in accordance with Mental Health and Addictions extreme high risk or high risk observations.

1.3 Patient / client group

This procedure applies to both known mental health service users / tāngata whaiora and those presenting at Waikato Hospital that are under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

1.4 Exceptions / contraindications

Forensic inpatient service users / tāngata whaiora who have been transferred to Waikato Hospital to receive medical treatment will be managed by forensic clinical inpatient staff – Senior Medical Officer (SMO) and nursing staff.

This procedure does not apply to hospital facilities outside of the Waikato hospital campus.

1.5 Definitions

EHRO – Extreme High Risk Observations	Extreme High Risk Observations: Within eyesight and arms reach at all times. Impulsive and imminent risk of violence to self / others and unable to be safely managed on any lower level of observation. One designated staff member to one service user / tāngata whaiora and sometimes two or three designated staff members (dependent on assessed level of risk) to one service user / tāngata whaiora (Refer Levels of Observation in Inpatient Services procedure (5238))
HRO – High Risk Observations	High Risk Observations:

	Same room and within eyesight at all times. Service user / tāngata whaiora expressing active suicidal, self-destructive, aggressive and / or an unpredictable psychotic state. Within same room and eyesight of the designated staff member at all times and within a distance to safely intervene should the service user / tāngata whaiora become a risk to themselves or others (Refer Levels of Observation in Inpatient Services procedure (5238)).
LOO – Levels of Observation	The Levels of Observation required are identified to ensure the assessed risk of the service users / tāngata whaiora can be safely managed (Refer Levels of Observation in Inpatient Services procedure (5238))
Service user	A person who uses mental health services. Some people do not identify with the term 'user' and may instead prefer 'patient', 'client', 'consumer; and / or 'tāngata whaiora (or whatever people choose to name their experience)

2 Clinical Management

2.1 Roles and Responsibilities

Assigned registered nurses

Increase of observations must always be considered following any change of the service users / tāngata whaiora behaviour, circumstances and or at a transition point. A proactive approach to communication and escalation of service user / tāngata whaiora condition based on any assessment of deterioration must be performed.

Senior Medical Officer (SMO) or Delegate

The medical team is responsible for assessing and reviewing levels of observation. Service users / tangata whaiora on high or extreme observations must be reviewed daily at a minimum by a consultant. This may require a handover to the after-hours / on call SMO.

Mental Health Bureau – Associate Charge Nurse Manager (ACNM) / Coordinators

Have oversight of and provide coordination in provision of mental health and addictions staff to complete the high risk observations.

Consult Liaison Team

Are responsible for oversight of the service user / tāngata whaiora ongoing mental health management / needs

2.2 Competency required

All mental health clinical staff must have completed their Ko Awatea Level of Observation training.

2.3 Equipment

- Clinical record – Clinical Workstation (CWS) and Hospital Clinical Record
- High Risk Observation (HRO) recording sheet – T1572MHF
- High Risk Observation (HRO) continuation sheet – T1056MHF
- Radio Transmitter

2.4 Procedure: Transfer of care from Henry Rongomau Bennett Centre to acute services

2.4.1 Mental Health service users / tāngata whaiora who are transferred from the Henry Rongomau Bennett Centre (HRBC) to the Emergency Department (ED) ward in Waikato Hospital

Transfers of HRBC service users / tāngata whaiora to ED will occur only after explicit discussion between HRBC medical staff and the Emergency Physician in charge (EPIC) when it is deemed there are medical issues which cannot be safely dealt with within the Henry Rongomau Bennett Centre.

An assessment by HRBC SMO / delegate to be completed

- Discussion between the Emergency Department / Ward SMO / Delegate about the pending transfer and acceptance by the Emergency Department
- Assessment completed in the clinical record by assessing Doctor, printed and any other relevant documents given to the accompanying registered nurse
- If clinically required, an ambulance is rung via the operator. If an emergency dial 99777
- The ward administrator will discharge the service user / tāngata whaiora during office hours. After hours the shift lead / afterhours Mental Health Bureau Associate Charge Nurse Manager ACNM (HRBC coordinator) will complete the discharge.
- The mental health treating team will make the decision about the level of observations required when the service user / tāngata whaiora is in ED or other wards and enact as per the Mental Health Levels of Observation in Inpatient Services procedure (5238).
- HRO are initiated for service users / tāngata whaiora who have been placed under the Mental Health Act.
- The Mental Health Bureau is then responsible for finding and coordinating the staff required. The cost of this will be attributed to the 'home ward's RC"

- An electronic referral is sent to Consult Liaison by the treating teams SMO / delegate with a follow up phone call. Evidence is documented in clinical workstation that this has occurred.
- HRBC inpatient treating team in collaboration with Consult Liaison will address the service user / tangata whaiora ongoing management / need based on their daily progress at the general hospital. During office hours the Consult Liaison team is responsible for the service user / tāngata whaiora's mental health oversight and ongoing communication with the treating medical / surgical team. The on call / duty SMO and delegate will be available to communicate with the medical / surgical team(s) after hours.
- Mental Health Bureau CNM / ACNM (HRBC Coordinators) will

  (a) oversee the management of the staff allocated to HRO:

  - ensuring adequate breaks,
  - the HRO recording sheet has been signed by the appropriate SMO,
  - Staff who are monitoring understand their responsibilities and sign the HRO continuation sheet accordingly,
  - Staff always have a radio transmitter present when monitoring the service user / tāngata whaiora.

  (b) Continue to visit each shift to oversee the management of the HRO, the wellbeing of the service user / tāngata whaiora and the mental health staff providing the monitoring. Outcomes to be recorded in the clinical record in the clinical workstation and the hospital clinical record
- Service users / tāngata whaiora under HRO will be reviewed daily by the treating SMO / delegate in Consult Liaison or by the on-call SMO over weekends and holidays – refer Mental Health Levels of Observation in Inpatient Services procedure (5238).
- It is important that service users / tāngata whaiora who have been under the care of Consult Liaison (CL) have a handover plan from Consult Liaison for the required psychiatric care for the weekend starting at 4.30 on Friday and ending 8.30 am on Monday morning. This should be handed over to the Mental Health Bureau CNM / ACNM (HRBC Coordinator) on Friday afternoon and should include all those service users / tāngata whaiora who require a review over the weekend.
- On Monday morning the Mental Health Bureau CNM is to provide Consult Liaison with an update of each service users / tāngata whaiora care over the weekend in order for Consult Liaison to develop a new care plan in consultation with the medical / surgical team.

2.4.2 Emergency department presentations

Those presenting at the Emergency Department, who are a known mental health service user / tāngata whaiora, or those presenting with a suspected mental health disorder.

The appropriate mental health service is contacted and documented in the clinical record.

Mental Health services will be notified to attend the service user / tāngata whaiora as soon as they are deemed fit to interview, which may be before they are medically cleared for discharge.

Day of week	Time	Contact information
Monday to Friday	0800 – 1600 hrs	Via electronic or the yellow referral form which is scanned to Consult Liaison mailbox CL@waikatodhb.health.nz
	1600 – 2300 hrs	Crisis Assessment and Home Treatment Team (CAHT) ph. 0800 505 050
	2300 – 0800 hrs	Via HRBC Coordinator
Saturdays, Sunday and Public Holidays	0800 – 2300 hrs	Crisis Assessment and Home Treatment Team (CAHT) ph. 0800 505 050
	2300 – 0800 hrs	Via HRBC Coordinator

- An assessment is completed by Mental Health services. The clinician will complete the IPM data requirements to meet the Ministry of Health 6 hour ED target.
- If the service user / tāngata whaiora requires admission to the HRBC this will need to be organised once the patient is medically cleared.
- The service user / tāngata whaiora may require compulsory psychiatric assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 while still in the Emergency Department or when transferred to a general hospital ward. Once the service user / tāngata whaiora is under the Mental Health (Compulsory Assessment and Treatment) Act the Mental Health Levels of Observation Inpatient procedure (5238) is commenced and becomes the responsibility of the Mental Health and Addictions service.
- The cost of the ongoing HRO will be met by the Mental Health Bureau (RC3234)
- The Mental Health Bureau ACNM (HRBC Coordinator) will arrange staff coverage (Ph: 021 222 0021)
- If the service user / tāngata whaiora remains in the general hospital ward an electronic referral form is sent to Consult Liaison for ongoing oversight of the service user / tāngata whaiora mental health issues.
- Consult Liaison will contact and make a referral to Kaitakawaenga for tāngata whaiora requiring Māori cultural support
- The Mental Health Bureau ACNM (HRBC Coordinator) will continue to visit each shift to oversee the management of the care being provided to the service user / tāngata whaiora, and the wellbeing and needs of the mental health staff providing the monitoring. Service user / tāngata whaiora outcomes from this visit are to be recorded in the clinical record in the clinical workstation and the hospital clinical record.

- Care partners are used for a variety of reasons. Mental Health and Addictions services will only bear the cost of patients on HRO as per the Mental Health Levels of Observation Inpatient services procedure (which means those under the Mental Health (Compulsory Assessment and Treatment) Act 1992 with associated risk issues).

2.4.3 Points of note

- HRO by Mental Health and Addictions services are not used in the management for falls risk, delirium or intoxication

2.4.4 After hours assessment of children and youth in the Emergency Department

- Refer to the Mental Health and Addictions After Hours Assessment and Admission of Children and Youth to Henry Rongomau Bennett Centre and Starship procedure (2768)

3 Audit

3.1 Indicators

- Part of mental health and addictions service audit process for the Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (5238).
- Any issues identified are highlighted to the Mental Health inpatient Operations Manager

3.2 Tools

- DATIX incident reporting
- Complaints

4 Evidence base

4.1 References

- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendments 1999
- Ministry of Health (2019) Every Life Matters – He Tapu te Oranga o ia tangata Suicide Prevention strategy 2019 – 2029 and Suicide Prevention Action Plan 2019 – 2024 for Aotearoa New Zealand. Wellington: Ministry of Health.

4.2 External Standards

- Standards NZ (2008). Health and Disability Service Standards. Wellington: Author

4.3 Associated Waikato DHB Documents

- Mental Health and Addictions After Hours Assessment and Admission of Children and Youth to Henry Rongomau Bennett Centre and Starship procedure (2768)
- Mental Health and Addictions Level of Observation Inpatient Services procedure (5238)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others protocol (5241)
- Waikato DHB Admission, Discharge and Transfer policy (1848)
- Waikato DHB Incident Management policy (0104)
- Waikato DHB Restraint policy (2162) and procedures
- Waikato DHB Suicide or deliberate self-harm thought or behaviour, management of patients policy (1811)

Opioid Substitution Treatment (OST)

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions
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Document Facilitator Title	Operations Manager
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Document Owner Title	Clinical Director CADS
Target Audience	Te Whatu Ora Waikato Community Alcohol and Other Drug Service (CADS)
Disclaimer: This document has been developed by Te Whatu Ora Waikato specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Te Whatu Ora Waikato assumes no responsibility whatsoever.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
03	Operations Manager	August 2022	Changed to a Guideline from a Protocol Changed to Te Whatu Ora template Adult Deterioration Detection (ADDS) chart changed to Early Warning Scoring System (EWS) Chart Included Lead OST clinician in definitions Included Peer Support in definitions Full review of document
02	Charge Nurse Manager AOD and Clinical Director	August 2017	The MOH (2014) New Zealand Practice Guidelines for OST is acknowledged by Waikato DHB as being the overarching guidelines for the CADS OST program. Therefore this protocol has been condensed to exclude information that is written in these guidelines. Induction of OST is to be monitored by Registered Nurses, removing other health professionals from this stage of treatment. Recovery plans, formerly known as treatment plan, are to be reviewed 3 monthly (as per DHB policy) rather than 6 monthly as per previous policy. Consumer photos are scanned to the pharmacy rather than faxed to reduce risk of error
02		February 2018	Document changed to Protocol from Policy

Opioid Substitution Treatment (OST)

Contents

1 Overview

1.1 Purpose

This guideline outlines how the Te Whatu Ora Waikato Community Alcohol and Other Drug Service (CADS) provide Opioid Substitution Treatment (OST) to tāngata whaiora who are opioid dependent, in a safe and appropriate manner, in accordance with the Prescribing Controlled Drugs in Addiction Treatment, section 24 of the Misuse of Drugs Act (MODA) 1975.

1.2 Service Overview

Te Whatu Ora Waikato Community Alcohol and Other Drug Service (CADS) comprises three main bases: Hamilton (Central North and Central South), Rural South, and Rural North (Hauraki), which provide evidence based interventions based on the theories / models of harm reduction, recovery and strength-based approaches alongside medical assessment and treatment. CADS prescribe and treat in a safe and appropriate manner in accordance with the Prescribing Controlled Drugs in Addiction Treatment, section 24 of the Misuse of Drugs Act 1975.

While meeting responsibilities under this guideline, CADS aims to uphold the articles and intent of Te Tiriti o Waitangi including Kāwanatanga, Tino Rangatiratanga, Ōritetanga and Wairuatanga.

Objectives

The key objectives of OST in Aotearoa are to:

- improve the physical and psychological health and wellbeing of tāngata whaiora who use opioids
- support tāngata whaiora in the reduction or cessation of illicit opioid use
- Be accessible and responsive to the needs of the community
- Provide culturally appropriate services and support to tāngata whaiora and their whānau
- Initiate and promote tāngata whaiora and whānau recovery journeys and access to recovery support systems and networks
- Provide a range of psychological and psychosocial interventions to support the tāngata whaiora and whānau in their recovery
- Work in collaboration with other community services such as Ara Poutama – Department of Corrections, social support / welfare agencies, pain clinics, maternity services and emergency services.

Working under the Ministry of Health Opioid Substitution Treatment (OST) Guidelines (2014), Te Whatu Ora Waikato CADS delivers an OST service with the aim of reducing harm to tāngata whaiora, working towards reducing risk to the community by preventing the spread of blood borne viruses such as Hepatitis C and B, HIV, and to reduce crime associated with dependence behaviours and reduce the risks to whānau. Educational support and resources will be incorporated into treatment.

1.3 Staff group

This guideline is applicable to staff working in Te Whatu Ora Waikato Community Alcohol and Other Drug services who treat tāngata whaiora who are opioid dependent with OST and staff who are working in a CEP approach.

1.4 Patient / client group

This guideline relates to tāngata whaiora who have been assessed as being opioid dependent as defined by the DSM V, DSM IV-TR or ICD 10 classification systems and who meet the criteria (see 2.4.1) for the OST programme provided by CADS and for those whom OST is utilised specifically for harm reduction eg when a tāngata whaiora is poly substance (including opioids) dependent.

1.5 Exceptions / contraindications

Tāngata whaiora are excluded from this guideline if:

- They are not opioid dependent
- They have clinically significant hepatic disease or respiratory insufficiency
- They are unable to, or choose not to, provide informed consent
- Opioid dependency cannot be confirmed

1.6 Definitions and acronyms

CADS	Community Alcohol and Other Drug Service
Keyworker	Keyworker refers to health professionals (e.g. Registered Nurses, Social Workers, Psychologist, Alcohol and Other Drug Clinicians, Occupational Therapists) who are responsible for providing care to tāngata whaiora and their whānau (e.g. individual one to one work, medication monitoring, group facilitation, psychosocial interventions, working with whānau). (Refer to Keyworker Procedure – 1558)
Opioid Substitution Therapy (OST)	In Te Whatu Ora Waikato CADS, OST refers to prescribed methadone or Buprenorphine / Naloxone combination
Lead OST Clinician	A senior specialist medical practitioner appointed by Director of Mental Health, under the Misuse of Drugs Act 1975.
Peer Support	Peer support workforce involves a number of roles carried out by people with lived experience. These roles work alongside tāngata whaiora in their recovery providing information and support and assisting them to connect with community supports and advocacy services. They also provide a service user perspective to service providers and promote tāngata whaiora rights and resources.

2 Clinical management

This Te Whatu Ora Waikato OST guideline aims to support the recovery of tāngata whaiora with opioid dependence by improving the access to safe clinical OST through:

- Providing comprehensive assessment for substance use and related issues
- Providing a choice of treatment options
- Providing treatment and interventions that are strength-based
- Individualised treatment planning in conjunction with tāngata whaiora and whānau within a recovery and wellbeing-focussed model
- Supporting tāngata whaiora and their whānau to define and achieve their goals in ways that is acceptable to them
- Recovery planning and the provision of psychosocial support to assist tāngata whaiora and their whānau to build and maintain support and wellbeing structures that enable recovery
- Promoting long-term health and wellbeing which includes, but is not limited to, smoking cessation, CEP, dental care and improving social situations to support ongoing recovery.
- Providing medical assessment by CADS doctor or CADS Nurse Practitioner to maximise medication efficacy and OST related medical issues
- Working in collaboration with General Practitioners, Nurse Practitioners, and community pharmacies to meet the objectives of OST,
- Assisting tāngata whaiora with the safe introduction to and withdrawal from OST medication as appropriate

2.1 Roles and responsibilities

All roles are underpinned by the principles and values of harm reduction approach, recovery-centred practice, non-judgemental, being empathetic and working collaboratively

OST prescribers

The prescriber (authorised Medical Officer or Nurse Practitioner), is responsible for the effective and safe prescription of opioid substitution medication. They are accountable to the Lead (OST) Clinician, working in accordance with the Ministry of Health (2014) OST guidelines (and subsequent versions) and associated Te Whatu Ora Waikato CADS procedures and guidelines.

They will:

- Prescribe and assess dose suitability as required
- Implement systems (eg takeaway regimes) that support recovery, minimise risks for tāngata whaiora
- Utilise harm reduction strategies that support tāngata whaiora treatment goals
- Work collaboratively with tāngata whaiora, whānau, other members of the MDT, particularly the keyworker, and liaise with other health professionals to ensure any treatments for co-existing disorders occur within an integrated framework.

CADS Clinicians

Keyworkers will perform their duties according to the Ministry of Health (2014) OST guidelines (and subsequent versions) and associated Te Whatu Ora Waikato CADS procedures and guidelines. Keyworkers are responsible for:

- supporting tāngata whaiora to work towards goals of sustained reduction of, or abstinence from, opioids and other substances
- supporting tāngata whaiora to identify strategies to achieve their recovery goals & ensuring plans are updated and current
- supporting tāngata whaiora to attend medical reviews with the CADS doctors / Nurse Practitioner within the appropriate timeframes
- ensuring completion of relevant scales (e.g. Alcohol and Drug Outcome Measures (ADOM))
- ensuring risk assessments and associated documentation are updated and current
- offering or arranging for, psychosocial interventions that will support recovery
- Utilize harm reduction strategies to support lifestyle changes
- Refer to other support services to ensure tāngata whaiora and whānau are well supported in the community.

Registered Nurses

Registered Nurses will be identified as the keyworker for tāngata whaiora undergoing stabilisation on OST. Registered Nurses are responsible for completing physical health parameters, including baseline observations:

- ECG
- Clinical Opioid Withdrawal scale (COWS),
- Urine Drug Screening (UDS) and potentially metabolic screening
- Recording all observations on the Early Warning System chart (EWS)

2.2 Competency required

Clinicians will have a minimum of a certificate in AOD / Health Science in addition to their clinical qualification.

All clinicians will undergo orientation, mentoring and supervision to enable them to develop experience and competence in the provision of OST. A clinician new to OST will work alongside an experienced senior staff member to understand how OST medication works, the dispensing regime and changes, medical reviews, needle use / safety, read the national guidelines and the Te Whatu Ora guidelines, urine drug Screens, COWS and how psychosocial interventions can support harm reduction

All clinicians are engaged in regular professional supervision and have access to ongoing specific support for OST from experienced clinicians and also through participating in MDT discussions and training / education.

2.3 Equipment

- Sphygmomanometer
- ECG machine
- Urine drug screen containers

2.4 Guideline

2.4.1 Entry Criteria

- Prospective tāngata whaiora must be 18 years or older and able to provide informed consent
- If under the age of 18 years, consent must be given by parents / caregiver. If the tamariki / rangatahi is under the age of 16 years, the assessment must be supported by both an addiction specialist and a child or youth psychiatrist
- The tāngata whaiora must be assessed as being opioid dependent as defined by the DSM V, DSM IV-TR or ICD 10 classification systems
- The tāngata whaiora must agree to comply with the Opioid Substitution Treatment (OST) Agreement and provide written consent to induction and stabilisation.

2.4.2 Comprehensive Assessment

A comprehensive assessment, which can be undertaken by any health professional in CADS, is essential to initiating OST. The assessment is carried out during face to face appointments between the tāngata whaiora and the clinician, and wherever possible the comprehensive assessment should, with consent, include input from the tāngata whaiora whānau / support people.

The clinician who completes the assessment then presents it to the multidisciplinary team, which must include, at a minimum, a CADS doctor or CADS Nurse Practitioner and one other staff member. The MDT will then make a decision about the suitability of the tāngata whaiora to enter OST.

Priority placement on the programme is to be given to opioid dependent people who are:

- Pregnant
- HIV positive
- Māori, Pasifika
- Under the age of 18 years
- Responsible for the care of young children
- Stable and transferring from one centre to another within New Zealand
- Returning to New Zealand from overseas
- Diagnosed with co-existing physical and / or mental health problems

- Tāngata whaiora who have relapsed after coming off OST (with the exception of those on an involuntary stand down)
- Integration into the community after being recently released from prison and have previously been a tāngata whaiora of the CADS service.
- On home detention or receiving another form of community sentence and have previously been a tāngata whaiora of the CADS service.

2.4.3 Treatment planning and management

Assessments will be accompanied by an individualised recovery plan developed in collaboration with tāngata whaiora and their whānau which includes wellbeing and recovery goals, strengths, actions and priorities. Recovery plans will be regularly reviewed and updated at least every 3 months or at point of change, and a copy of the recovery plan will be given to the tāngata whaiora and disseminated to healthcare professionals also involved in the person's care (e.g. GP, pharmacist, midwife etc.).

Ideally, the tāngata whaiora's whānau is actively involved in assessments, treatment planning and transfer of care. Information and education to be offered to whānau about the OST programme such as "Real people share their stories of opioid substitution treatment" and "OST and you." Whānau can also be referred to NGO services for support.

2.4.4 Tāngata whaiora information and consent

Prior to commencing OST, tāngata whaiora must have understood and signed consent for treatment. Service providers will provide tāngata whaiora and their whānau information about treatment options and the side-effects of any proposed medication, the purpose of the OST programme, pathway, expectations and responsibilities. This information should be given verbally, and in writing for them to take away. Service providers will ensure there is a shared understanding between the service provider and tāngata whaiora and whānau to ensure informed consent.

In addition, service providers will give tāngata whaiora and whānau written information on:

- Their rights under the Code of Health and Disability Services Consumers' Rights 1996
- The obligations / responsibilities of the Te Whatu Ora CADS in providing a safe and effective service as per Section 11.3 Rights of people receiving OST, Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand
- The benefits, side-effect, and limitations of opioid substitution medicine – including the increased risk of overdose during induction as per Section 4.1 Overdose, Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand
- The potential effect of opioid substitution medication on activities such as driving and operating machinery as per Section 4.2 Substance impaired driving, Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand

- The interactive effects of opioid substitution medication with alcohol and other substances (prescribed and illicit) (Appendix 5 Drug Interactions, Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand)
- The possible need for an electrocardiogram before commencing and during OST (with methadone) to establish QTc as per section 4.3 Methadone and cardiac safety, Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand)
- All mechanisms for making a complaint including the Te Whatu Ora Waikato complaints process, the Health and Disability Commissioner and the tāngata whaiora rights to an independent advocate / support person
- The availability of consumer advocacy and peer support services as well as whānau support services.
- Tāngata whaiora and their whānau are given a CADS Welcome Pack.

2.4.5 Phases of Treatment

There are three phases of the continuum of care during which certain steps should be followed to support tāngata whaiora ongoing recovery: induction, stabilisation and transfer to General Practitioner Shared Care. The length of time a tāngata whaiora spends in each phase varies and is largely dependent on their needs. Regular reviews with tāngata whaiora and whānau throughout the three phases will include discussion about whether OST remains the most effective treatment pathway as well as the effectiveness of psychosocial and psychological interventions.

Induction phase

Induction into OST requires the balancing of an adequate dosage of OST with elevated risk of overdose as opioid levels accumulate. Induction is generally for the first 7-10 days from beginning OST. This phase begins with an assessment with a Registered Nurse and involves:

- Collecting two urine drug screens taken on different days which are opioid positive
- Providing the tāngata whaiora and whānau with information on methadone and Buprenorphine / naloxone to take away and read
- A contract and consent to treatment is signed
- A driving agreement is signed
- Information about Hepatitis B and Hepatitis C and associated long-term health consequences
- Baseline observations and ECG are completed to primary determine baseline QTc
- Present assessment to a CADS doctor or CADS Nurse Practitioner to arrange time for the initial medical review
- A photo taken and uploaded to the photo folder on the AOD shared resource file on the shared drive (Data04) with the tāngata whaiora name and NHI number clearly

recorded with a copy scanned and sent to the dispensing pharmacist with the first prescription. Photos should not be uploaded to the Clinical Workstation (CWS) due to file size.

At initial medical review with a CADS Doctor or CADS Nurse Practitioner

- The tāngata whaiora is diagnosed with opioid dependence
- The CADS doctor / CADS Nurse Practitioner will reassess suitability for OST
- A plan is formulated with the tāngata whaiora, whānau and keyworker present for induction day, OST drug of choice and starting dose
- Tāngata whaiora is informed when to stop using illicit opioids and what to expect from the treatment
- Informed consent is obtained

Reviews

Tāngata whaiora receiving OST should be seen by a CADS doctor or Nurse Practitioner at least once during the first seven days of treatment and face to face by their keyworker at least weekly during the induction phase. The review process allows clinical staff to monitor tāngata whaiora progress, identify and address any safety issues, hear from the tāngata whaiora and their whānau about concerns, and to provide an opportunity to further reduce harm.

Stabilisation phase

During this phase the tāngata whaiora should have achieved an adequate opioid dose, be attending regular appointments with their keyworker and prescriber reviews, and be making progress towards their recovery goals, enhanced by psychosocial interventions.

Psychosocial support and interventions promote harm reduction by maximising access to interventions addressing people's wider needs, including physical, emotional and social needs, along with those of whānau. Interventions should be evidence-based and recovery focussed and based on individual needs

During the stabilisation phase, reviews by CADS doctor or Nurse Practitioner will occur at least 3 monthly, then at least every 6 months once stabilisation is achieved. Tāngata whaiora and whānau are to be seen by their keyworker at least once every 6 weeks during the stabilisation period.

Multidisciplinary team (MDT) reviews, which include the keyworker, the doctor or Nurse Practitioner and at least one other health professional from the service will be completed at least every 3 months. A record of the review, which will include progress towards treatment and recovery goals as well as decisions about takeaway doses, must be documented in CWS.

Inclusion of the tāngata whaiora and / or whānau in multidisciplinary team reviews is expected.

Transfer to GP shared care

Transfer to the GPSC programme occurs when the tāngata whaiora is stable on the OST programme (as per stability criteria in section 2.4.8 of this guideline) is not using illicit substances, and is working towards employment and / or employed. Transfer is facilitated by the prescriber and key-worker in consultation with tāngata whaiora and their whānau Planning for transfer should being when tāngata whaiora is inducted on to the programme and should be reflected in treatment and recovery goals and discussed with the tāngata whaiora and whānau as part of regular reviews.

2.4.6 Drug Screening

Random monitoring of tāngata whaiora substance use will take place by requesting urine for drug screening, to support the tāngata whaiora to validate self-reporting of use and help guide takeaway OST dose regimes in association with other relevant factors. The result should be discussed with the tāngata whaiora. Observed urination is not required unless the keyworker or prescriber are suspicious of authenticity of the sample, for example temperature of sample, colour, or diluted sample. Should an observed sample be required the observer should be the same gender as the tāngata whaiora where possible and if not possible, only to be done with the consent of the tāngata whaiora providing the sample. For tāngata whaiora who identify as transgender they will be asked which gender for the observer they are more comfortable having observe them.

2.4.7 OST Scripting and Dispensing

Scripting and dispensing of OST is carried out as per Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand which includes transfer of care between two services.

Change of Dose

Dose determination should be based on both subjective reports from the tāngata whaiora, clinical judgement, and may include the use of blood serum level testing. It is important to recognise the relationship between inappropriate OST doses, continued injecting drug use, and risk of hepatitis / HIV and other blood borne diseases or health complications.

Any dose changing requests to the keyworker should be discussed with the prescriber at the earliest opportunity.

Replacement Doses

Replacement doses and reintroducing OST after missed doses is carried out as per the Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand. CADS does not replace lost, stolen or spilt OST take away doses.

OST and Injection Use

- When a tāngata whaiora is identified as injecting, they are provided education and informational support about safe injecting practice e.g. needle exchange, clean use, not sharing needles or equipment, swabs and filters.
- Take home doses will be stopped (decision can be made on a case by case basis) when they are injecting the takeaway doses to ensure the tāngata whaiora safety and more frequent keyworker appointments should occur to monitor other drug use, minimise risk and review recovery plan and goals.
- A clinical review for recovery planning with the MDT will occur at the next available MDT meeting which are held weekly.

Take Home Medication

The Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand are followed.

2.4.8 Stability Criteria

The MDT will make decisions regarding take-home OST eligibility in consultation with tāngata whaiora and their whānau, recognising that flexibility in dispensing arrangements can improve tāngata whaiora / whānau independence and quality of life. Requirements to consume OST on pharmacy premises, number of takeaways, and suitability for GP-shared care will be routinely reviewed at least every three months.

Factors taken into consideration in determining responsible behaviour and stability include:

- Absence of intoxication with other drugs, including alcohol
- Negative urine drug screen for other drugs
- Regularity of appointment attendance and adherence to treatment plan
- Absence of serious behaviour problems at CADS or pharmacy
- Absence of known recent criminal activity
- Length of time in stable treatment
- Level of responsibility regarding care of medication, whether medication is taken as directed (e.g. absence of intravenous methadone use or doubling up of medication)
- Stability in home environment and social relationships
- Ability to manage crises appropriately
- The safety of Tamariki / rangatahi and others in the household is assured
- Whether the rehabilitative benefit to the tāngata whaiora, derived from reducing the frequency of consuming doses at the pharmacy outweighs the potential risk of diversion or abuse.

Positive factors to be considered:

- Take-home medication will aid in the management of tāngata whaiora concurrent medical or psychiatric disorder(s)
- The tāngata whaiora adheres to treatment for concurrent medical or psychiatric disorder(s)
- Take-home doses may be appropriate in an emergency situation, such as personal, whānau crises, bereavement, pandemic, or other hardship

Factors which may determine a decision NOT to provide take-home methadone:

- The tāngata whaiora is diagnosed with a co-existing disorder that may be complicated by self-administered methadone, buprenorphine / naloxone and may require daily observation by the pharmacist
- The tāngata whaiora unstable home environment or complex whānau relationships increase the risk of diversion or unauthorised use of the medication.

2.4.9 Temporary changes in dispensing regime

Hamilton CADS

- Any changes are to be signed off by two Alcohol and Drug health professionals (the keyworker and one of the following: CADS doctor, Nurse Practitioner, Charge Nurse Manager / Team Leader or delegate). This must be preceded by a review of recent entries in the tāngata whaiora clinical workstation notes, including recent urine drug screen results and the outcome of the medical reviews. The co-signing clinician shares accountability for the clinical decision.

Rural North and South Waikato CADS

Sign off will be by two Alcohol and Drug health professionals from within their rural CADS teams, due to the rural teams not having access to a doctor on site. This must be clearly documented in CWS.

Changes to take-away regime

Tāngata whaiora in the stabilised phase of OST may request a change in days to consume on premises (COP)

- The request to make a change to consume on premises (COP) regime should be made directly to their keyworker who will then discuss the request within the MDT meeting or if not practicable, the prescriber or team leader (or second in charge)
- In this circumstance a minimum of **2 working days' notice** to the keyworker is required (to allow the necessary paperwork to be completed)
- Occasionally if resource allows, changes may be approved at short notice for emergency situations such as whānau bereavement

- The written authorisation for a change of regime should be scanned and emailed to the pharmacy and receipt confirmed by telephone. Only thereafter may the change be dispensed to the tāngata whaiora.
- A hard copy of the authorisation is then uploaded into CWS.

Removal of take-away regime

- Where there are sufficient concerns regarding tāngata whaiora stability, the team may decide, in the interest of tāngata whaiora safety that OST medication should be returned to daily dispensing
- A team decision to cease take-away doses should be communicated to the tāngata whaiora by the keyworker prior to the prescription change
- Reinstatement of the take-away doses is determined on a case by case basis and should occur after MDT discussion and two urine drug screenings (UDS) positive for methadone metabolites only.

Temporary transfer of pharmacy

Tāngata whaiora in the stable phase of OST may request a temporary transfer of their OST medication prescription to another dispensing pharmacist.

- The request should be made directly to their keyworker within a minimum of **2 working days of the temporary change**, who will then discuss this within the MDT. If not possible due to time constraints, then:
  - In Hamilton CADS, the keyworker will discuss the change with the prescriber, Nurse Practitioner or Charge Nurse Manager / Team Leader or second in charge
  - In rural CADS the decision will be discussed by the keyworker and a second health professional
  - Short notice transfers may be approved under emergency situations, such as a whānau bereavement or similar
- A suitable pharmacy in the area to which the tāngata whaiora is travelling should be identified either by the clinician or the tāngata whaiora; the pharmacy's willingness to dispense must be confirmed by the service
- A transfer script, Temporary Change of Community Pharmacy form and tāngata whaiora photograph (for identification) is scanned to the temporary pharmacy and a copy of the Temporary Change of Community Pharmacy form scanned to the current pharmacy and phone contact made immediately afterwards to confirm receipt
- Planned holidays require at least two weeks' notice and a MDT discussion. Tāngata whaiora should be encouraged to nominate pharmacies to which prescriptions can be transferred on planned holidays.

Out of area transfer

Tāngata whaiora who have moved and relocated into other specialist service areas are to be transferred to the nearest OST provider.

- Contact is made by the current keyworker to the new service, to request what transfer details are to be provided
- The tāngata whaiora will be expected to attend any medical reviews with the prescribing service whilst the transition occurs
- The referring service will prescribe OST medication until the transfer service has assessed, medically reviewed and accepted the tāngata whaiora, with a start date for prescribing advised
- Once prescribing is started by the service, CADS Waikato will discharge the tāngata whaiora from OST
- As per Ministry of Health expectations, it is expected that the transfer will be accepted within three months. The lack of transfer within this timeframe must be escalated to the Charge Nurse Manager / Team Leader and Clinical Director.

Tāngata whaiora who have relocated to the Waikato region and a referral received from the current prescribing service:

- Will be contacted by an allocated clinician for an updated comprehensive assessment which should be presented in conjunction with assessment and details from the previous service to a MDT forum for acceptance into the Waikato OST programme
- A medical review with a CADS doctor or CADS Nurse Practitioner is booked and once attended, a start date for prescribing can be negotiated
- The referring OST service is notified as to the date of prescribing by the new service.

Overseas travel

- Overseas travel may take up to six weeks to organise. Tāngata whaiora must be advised at the induction stage of the necessity to give 6 weeks' notice of planned overseas travel
- If the tāngata whaiora requires take-away doses to be carried on their person CADS must make contact with the country's consulate to determine if that country allows methadone or Buprenorphine / Naloxone into their country and what documentation is required to carry the OST medication into their country. The prescribing service must adhere to any special conditions required for entry, and a letter provided by the prescriber to state the person is in possession of the drug for treatment of a medical condition.
- Tāngata whaiora should only be provided with sufficient OST to cover them during transit allowing them to attend a dispensing pharmacy in the respective country if treatment has been organised there. Alternatively, take-away medication is provided for travel of a reasonable duration. Safety should be a paramount concern when considering how many take-away doses should be allowed.

2.4.10 Third party information

Third party information can be received from any source including:

a) a pharmacist, police, or other government agencies involved in tāngata whaiora treatment or care, and

b) other tāngata whaiora or members of the public.

In case of informants from group a) the information can be accepted as first party information and appropriate action taken after multidisciplinary team discussion in regards to safety issues for the tāngata whaiora, community and prescriber.

In the case of information from group b) the tāngata whaiora can be informed (confidentially) of the information received and asked to confirm or deny any allegations; the information and the tāngata whaiora response are documented. Due to lack of confirmation of the allegation it would be difficult to act on unless there is further information in relation to the tāngata whaiora. MDT discussion should occur and appropriate warning given to the tāngata whaiora should there be risk to the tāngata whaiora, community or prescriber.

2.4.11 Driving and OST

Tāngata whaiora will be given the CADS OST and driving agreement from the outset of treatment, which is to be signed and uploaded to CWS. Providers have a responsibility to advise tāngata whaiora and their whānau of possible effects of OST and associated risk of impairment when their dose is increased and when they are known to be using or when they have been prescribed other medication that could contribute to impairment. This discussion will include informing the tāngata whaiora that if they present to CADS in an intoxicated state and staff are aware they are driving, they will be asked to leave the keys with staff. If the tāngata whaiora declines, the police will be contacted. Prescribers have a responsibility to take action if they become aware tāngata whaiora ability to drive has been impaired, considering the safety of both community and tāngata whaiora and whānau.

2.4.12 Prison

- If the tāngata whaiora is incarcerated in prison on remand then Waikato CADS will continue the prescribing. The prison medical team will get in contact with CADS to advise the tāngata whaiora is on remand and a Temporary transfer of community pharmacy Form and script is completed and prison medical team advised.
- If the tāngata whaiora is sentenced to prison then CADS can either continue to prescribe or authorise the prison medical officer (with the appropriate training) to prescribe
- If Waikato CADS are to prescribe for a tāngata whaiora who is in a prison outside of the Waikato region this will continue for three months by which time the CADS team in the area where the tāngata whaiora is, should take over prescribing as per Ministry of Health directive

- Six monthly medical reviews can be made in person or by video conference
- CADS prescribers are available via phone for authorised prison prescribers should they need advice.

2.4.13 Potential complications

OST and diversion and / or behavioural concerns at CADS or Pharmacy

At the induction stage the tāngata whaiora must have read, understood and signed the contract between themselves and the OST provider. The contract outlines the expectations and boundaries between the tāngata whaiora and the service and highlights that abuse, diversion or behavioural issues at CADS or the Pharmacy are breaches of the contract, and what the potential consequences of this could be on treatment and wellbeing. This information will be discussed with tāngata whaiora and their whānau in such a way that there is shared understanding and will also include strategies to manage such situations early to avoid situations occurring as much as possible.

Should a tāngata whaiora verbally abuse a CADS staff member or pharmacist, they will be sent a letter from the team outlining the zero abuse policy and cautioning adverse decisions around their dispensing regime should it occur again. An opportunity to discuss this should always be offered to the tāngata whaiora and whānau so that there is an understanding of the situation for the tāngata whaiora and whānau, and an opportunity to put strategies in place to mitigate risk.

- Further abuse will be followed up with a MDT review of regime and changes made to their treatment plan
- Continued abusive behaviour will result in their place on the OST program being reviewed by the clinical team
- Assaultive behaviour where other tāngata whaiora or staff are placed at risk, will be immediately reported to the Police.

Did not attend (DNA) for case management and medical review
Medical reviews and keyworker engagement in appointments are an important part of recovery while receiving OST. The keyworker will follow the Mental Health and Addictions Appointment Planning and Did Not Attend Management with Tāngata Whaiora Procedure (0900).

It is an expectation that the keyworker or an administrator will contact the tāngata whaiora, via phone call of text, either on the morning of or day prior to the appointed medical review, as per an agreement made with tāngata whaiora about reminders, to remind them of the pending appointment.

Whilst emphasis is on clinicians understanding the reasons tāngata whaiora are not attending appointments and identifying strategies to support attendance, ongoing non-attendance is likely to result in a medical review with a CADS Doctor or CADS NP and review of take-away doses or after a third non-attendance, a reduction in the dose of OST prescribed.

Pharmacy Protocol

Pharmacists are an important part of the OST multidisciplinary team and play a key role in monitoring tāngata whaiora progress and wellness, or observing concerns such as intoxication, diversion or behavioural issues. Liaison with the pharmacist around changes in variation of prescribing regime, transfer of pharmacy and any concerns can add valuable information for case reviews within a multidisciplinary team forum and keeps the pharmacist informed of changes so they can make the necessary preparation.

Pharmacies are expected to notify in writing, which is then uploaded into CWS the prescribing service when the tāngata whaiora:

- Fails to collect their dose
- Presents as intoxicated at the point of dispensing
- Exhibits abusive or threatening behaviour
- Diverts or makes a serious attempt to divert
- Exhibits withdrawal symptoms
- Deteriorates in their physical, emotional or mental state

These reports should be handled as confidential to protect the safety of the pharmacist. The prescribing service is expected to:

- Actively seek input from pharmacists to assist multidisciplinary team decisions
- Liaise with the pharmacist in terms of change of variation to dispensing regime
- Inform the pharmacist of transfer, temporary or permanent. Details sent by email and informed by phone
- Understand that changes in doses or new scripts are time consuming for the pharmacist and except in emergencies should coincide with the next scripting cycle
- Provide pharmacies with education / training on harm reduction, reducing stigma, de-escalation.

2.4.14 Exit protocol

- Reduction from OST should only be considered when the tāngata whaiora has achieved stability and achieved mutually agreed treatment goals.
- Any withdrawal from treatment should include a high level of psychological support, relapse prevention interventions and medical supervision. However, some tāngata whaiora may decline such supports and interventions, and this should be respected.
- It is critical that the person going through the withdrawal from OST receives clear and accurate information of the process in order to manage increased levels of anxiety.
- Tāngata whaiora and whānau must be informed of increased risk of accidental overdose if they relapse to substance use, particularly opioids, due to a decrease or loss of tolerance.

- Counselling, medical, psychosocial input along with increased support from CNS or Nurse Practitioner should be increased during the withdrawal phase and should be continued once the reduction regime has finished, in order to help prevent relapse.
- A comprehensive discharge plan must be developed (including biological, psychological and social strategies that can help to minimise the discomfort associated with OST discontinuation) and documented once the tāngata whaiora and / or service provider has decided to commence a withdrawal regime from opioid substitution treatment.
- An involuntary discharge from CADS is a last resort and is only made after considerable discussion
- The tāngata whaiora must be aware of the reasons for the involuntary discharge, the stand down time, their right to appeal and complain and how to access support
- The tāngata whaiora must be regularly reviewed; their clinical records are to reflect these reviews
- A case review will occur at the point of discharge.

Treatment termination

Occasionally, tāngata whaiora may succeed in gaining entry onto an OST programme who:

- Are not suited for treatment i.e. who have managed to convince the service provider to prescribe more OST mediation than is required or has given a fabricated drug use history
- Have been unable to achieve their recovery goals
- Consistently breach the agreement, in terms of behaviour or risks to self and others.

Treatment may be terminated if:

Criteria for treatment termination must be conveyed to and understood by all tāngata whaiora. These criterial should be applied fairly and without prejudice:

1. The benefits of treatment are outweighed by the negative outcomes and elements of risk, e.g. supply of OST to others, not complying with safety requirements
2. Staff safety is compromised e.g. violence to staff
3. The contract has been repeatedly breached
4. Repeated failure to keep a minimum of 4 monthly review meetings with the Medical Officer and a minimum of 6 weekly with the keyworker
5. The tāngata whaiora moves out of the area and fails to engage with OST services in their new area or fails to maintain regular medical reviews with the Waikato CADS while they are awaiting entry to the service in their new area

Where possible, verbal (face to face, or by phone) and written warnings should be provided prior to terminating treatment.

Prior to a decision being made to terminate treatment and where possible, a treatment review will be held. This is an opportunity for the tāngata whaiora, whānau and CADS to clarify expectations, review treatment progress and discuss other treatment options should this be appropriate.

Consideration should be given as to whether it may be possible to transfer the tāngata whaiora to another treatment programme rather than a complete withdrawal from methadone or Buprenorphine / Naloxone treatment.

A final decision to terminate treatment will be made by the MDT in the Complex Case Review MDT. When treatment termination has been decided upon, withdrawal management should be provided to the tāngata whaiora / whānau, including strategies / support for whānau to minimise the impact of withdrawal. The process of reengagement should be discussed with the tāngata whaiora / whānau and the team members with the criteria for this being explicit. The tāngata whaiora General Practitioner must be made aware that OST has ended. All decisions and information must be clearly documented in CWS.

3 Audit

3.1 Indicators

Ministry of Health (2014) Specialist Opioid Substitution Treatment Service Audit and Review Tool

4 Evidence base

4.1 Associated Te Whatu Ora Waikato Documents

- CADS Driving and methadone agreement
- CADS Treatment consent for induction on to OST (G2986MHF)
- Consent to Treatment (A3114MHF)
- Mental Health and Addictions Appointment Planning and Management of DNAs (Ref. 0900)
- Mental Health and Addictions Keyworker (Ref. 1558)
- Mental Health and Addictions Recovery Planning (Ref. 5998)
- Early Warning Scoring System for the Deteriorating Patient policy (Ref. 1540)
- Early Warning Scoring System for the Deteriorating Patient procedure (Ref. 1541)
- Informed Consent (Ref. 1969)
- Medication Security (Ref. 0003)
- Medicines Management (Ref. 0138)
- Your Rights (MOH) (G1136MHF)

4.2 External Standards

- Code of Health and Disability Services Consumers' Rights 1996
- Health and Safety at Work Act 2015
- Health Practitioners Competence Assurance Act 2003
- Human Rights Act 1993
- Ministry of Health (2014) Practice Guidelines for Opioid Substitution Treatment in New Zealand
- Prescribing Controlled Drugs in Addiction Treatment, Section 24 Misuse of Drugs Act 1975
- Privacy Act 2020
- Treaty of Waitangi Act 1975

Pharmacological Management of Behavioural Disturbance in the Acute Psychiatric Setting

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health & Addictions Service
Document Facilitator Name	Peter Dean
Document Facilitator Title	Clinical Director Acute Adult Mental Health and Forensics
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director, Mental Health and Addictions
Target Audience	Psychiatric doctors working with tāngata whaiora admitted under the Mental Health and Addictions inpatient service, and nursing staff involved in medication management and monitoring.
Disclaimer: This document has been developed by Te Whatu Ora Waikato specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Te Whatu Ora Waikato assumes no responsibility whatsoever.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes

Pharmacological Management of Behavioural Disturbance in the Acute Psychiatric Setting

Contents

Pharmacological Management of Behavioural Disturbance in the Acute Psychiatric Setting

1 Overview

1.1 Purpose

This guideline outlines the recommended pharmacological management of behavioural disturbance in the acute psychiatric setting in Te Whatu Ora Waikato for tāngata whaiora aged 18 – 65 years.

1.2 Scope

This guideline is relevant for Te Whatu Waikato Ora Mental Health and Addictions Service health professionals who are caring for tāngata whaiora admitted under the Mental Health and Addictions inpatient service. This guideline does not cover non-pharmacological methods of managing behavioural disturbance.

1.3 Tāngata whaiora / client group

Tāngata whaiora receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992, who meet criteria for pharmacological management of a behavioural disturbance.

Rapid tranquilisation must only be administered to tāngata whaiora who are subject to the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 for the purpose of acute behavioural disturbance management.

1.4 Exceptions / contraindications

In the process of rapid tranquilisation medications that a tāngata whaiora has had a previous reaction to should be avoided.

See section 2.5 of this guideline for precautions in administration.

For any tāngata whaiora with delirium follow the Te Whatu Ora Waikato Prevention, Diagnosis and Management of Delirium in Older People guideline (1106). For management of acute alcohol withdrawal, see the Te Whatu Ora Waikato Alcohol Withdrawal guideline (2672).

This guideline does not apply to children and adolescents, or to older adults and guidance must be sought from the specialty psychiatrist for these services. In addition guidance should be sought from consultation liaison psychiatry or a perinatal psychiatrist for treating tāngata whaiora who are pregnant or have underlying medical conditions of note.

1.5 Definitions and acronyms

Acute behavioural disturbance	Behaviour that puts the tāngata whaiora, or others at immediate risk of serious harm. Includes threatening or aggressive behaviour, extreme distress, and serious self-harm which could cause major injury or death. (New South Wales Guideline for the management of patients with acute severe behavioural disturbance in emergency departments)
Aggression	Verbal or motor activity that is hostile, injurious, or destructive in nature.

Agitation	A temporary extreme form of arousal that is associated with increased/excessive verbal and motor activity that breaks therapeutic alliance, and is in need of a prompt and immediate intervention.
Levels of observation	Levels of observation are defined in section 1.6 of the "Levels of Observation across all Mental Health and Addiction Inpatient Services' procedure. The levels of observation refer to the intensity and frequency of nurse monitoring, and are based on the mental status of tāngata whaiora, in addition to their risk to themselves and others. The level "Significant Risk Observations" indicates irregular intervals of up to 10 minutes between monitoring. The level "High Risk Observations" is specified as within eye sight and arms reach to be able to respond. The level "Extreme High Risk Observation" is specified as same room and within arm's reach at all times.
Rapid Tranquilisation	The use of the parenteral route to achieve a state of calmness, thereby reducing the risk to self/others while maintaining the ability of the tāngata whaiora to respond to communication. Sedation may also be considered an appropriate interim strategy.
Violence	Physical aggression by people against each other, or towards inanimate objects.

ABD	Acute Behavioural Disturbance
CNS	Central Nervous System
ECG	Electrocardiogram
ECT	Electro-convulsive-therapy
EWS	Early warning score (standardised early warning system to support clinical judgement and best practice)
IM	Intramuscular (medication route)
IMI	Intramuscular Injection
NMS	Neuroleptic malignant syndrome
PRN	As required
QTc	Corrected QT Interval on ECG

2 Clinical management

2.1 Competency required

Health practitioners in roles that require provision of pharmacological management of acute behavioural disturbance must be trained and working within their scope of practice. They must participate in a process of training and competency assessment, including as a minimum, basic life support.

Health practitioners who administer sedation must be compliant with the Te Whatu Ora Waikato Medicines Management policy (0138), and

- Have access to a resuscitation trolley as per the requirements of the Te Whatu Ora Waikato Resuscitation policy (1970).
- Be aware of: their jurisdictional requirements to report morbidity and mortality related to pharmacological management of acute behavioural disturbance.

Health practitioners who administer sedation must be compliant with the Te Whatu Ora Waikato Informed Consent policy (1969) and the Mental Health and Addictions Advance Directives procedure (2181).

These requirements are particularly important when there has been inadvertent deep sedation with an adverse outcome.

Training is available and highly recommended for ward staff on Safe Practice and Effective Communication, Sensory Modulation, and Trauma Informed care.

2.2 Facilities and Equipment

Ensure appropriate equipment is available for pharmacological management:

- Adequate room to perform resuscitation if necessary
- Sufficient lighting to aid with assessment of tāngata whaiora colour (such as cyanosis)
- Medication both in stock on the ward, and available through the pharmacy
- Equipment for IM administration of medication, and availability of water and cups for oral administration.
- Equipment for physical monitoring such as ECG machines (with sticky pads), stethoscopes, pen torches, reflex hammers, EWS observation chart, a neurological observation chart, sphygmomanometer (or other device for measuring blood pressure), pulse oximeter, and a device that measures time in seconds.
- Availability of a resuscitation trolley that includes a defibrillator (such as an AED), and reversal agents, and agents to treat allergic reactions in the case of serious adverse reactions to medication.

2.3 Principles

This guideline divides management of acute behavioural management into six levels as shown on the flow chart.

Non-pharmacological de-escalation must be the initial approach to managing acute behavioural disturbance. Verbal and environmental strategies may be utilised for de-escalation.

No guideline for managing acute behavioural disturbance is completely free from risk. Medication is used when de-escalation fails and must be used only when clinically indicated. It must never be used as a form of punishment for convenience, or as a substitute for other more appropriate treatments.

Aim to calm with light sedation. If two doses are given without effect, prompt the registrar to seek consultant psychiatrist advice. Avoid polypharmacy where possible (no more than two antipsychotic agents within a 24 hour period).

When intervening for acute behavioural disturbance, consider important factors such as known allergies/adverse reaction, previous response to medication, QTc, co-morbidities, current medications/substance use, and gross cognitive function (e.g. delirium, history of intellectual disability). Also consider important causes such as delirium, akathisia, intoxication, withdrawal, pregnancy, or other medical causes. It is also important to consider advanced directives, previous response to medication, adverse reactions, medication used over the past 24 hours and the past month, and the combination of PRN and regular medication.

Extra care must be taken when considering rapid tranquilisation in frail, medically compromised tāngata whaiora, and those with co-morbidities.

Repeated smaller doses of oral or IM medication to achieve the desired outcome are preferred to the use of a single larger dose because it reduces the risk of dose related adverse effects, and allows tolerance to be more accurately assessed. Frequent PRN IM injections of antipsychotic medication, particularly when used over extended periods of time, increase the risk of neuroleptic malignant syndrome.

Be aware of the total medication load in the previous 24 hours.

Example one: Lorazepam:

- If an initial dose of 1mg has been given, reassess after one hour and if the initial dose was insufficient, consider giving a further 1mg one hour post initial dose.

Example two: Olanzapine

- If an initial dose of 2.5mg has been given, reassess after one hour, and if initial dose was insufficient, consider giving a further 2.5mg one hour post initial dose.

Monitoring of tāngata whaiora with acute behavioural disturbance is vital at all stages of an intervention. Baseline physical observations are to be completed prior to administration and be documented on the Adult Vital Signs chart. Where this is not possible, the reasons must be clearly documented. Any concerns must be reported to the medical officer prior to administration. Monitoring must include a minimum of a nursing physical and mental health review every 10 minutes by a registered nurse for at least 60

minutes. See section 2.4.6 Level Six: Monitor and Review for further monitoring requirements

If the tāngata whaiora requires seclusion, monitoring of the individual must be "within eyesight" observation by a member of staff with competency.

Concise and accurate documentation of all medication administered, and the response to it, is required including rationale for changing medication.

Tāngata whaiora should be given an opportunity in the post-sedation phase to discuss the reasons for the administration of sedative or anti-psychotic medication and discuss the reasons for and circumstances of the episode.

Neuroleptic malignant syndrome (NMS) is an important and life threatening adverse event that can occur after the administration of antipsychotic medication. This syndrome is characterised by muscle rigidity, hyperthermia, altered consciousness, and autonomic instability (tachycardia, labile blood pressure, profuse sweating, and dyspnoea). The management of which should include immediate discontinuation of the antipsychotic drug, immediate transfer to a medical ward in the Waikato Hospital, and intensive monitoring and supportive care. ECT may be considered.

Some medications – for example benzodiazepine or promethazine - can be associated with paradoxical reactions such as agitation, disinhibition and violence. The incidence of paradoxical reactions in the general population is estimated to be ~1%. Learning disability, advanced age (over >65), age under 18 years, neurological disorders and impulse control problems are associated with an increased risk of paradoxical reactions.

2.4 Guideline

2.4.1 Level One: De-escalation

The first level is to not only use verbal de-escalation, and limit environmental stimuli, but recognise when there is an inadequate response to this with ongoing behavioural disturbance.

2.4.2 Level Two: Oral Monotherapy

Once non-pharmacological de-escalation has been attempted, consider oral monotherapy; if oral medication is refused, or does not provide an adequate response consider intramuscular therapy. If tāngata whaiora are on regular antipsychotics, consider utilising their regular medication, with due consideration of the maximum doses in 24 hours. Oral monotherapy can be subdivided into two categories; sedative and antipsychotic.

For sedative oral monotherapy, the recommendations are:

Sedative Medication	Dose	Maximum dose in 24 hours	Consider repeat dosing not before:
Lorazepam	1mg – 4mg	10mg	60 minutes
Promethazine	25mg – 50mg	100mg	60 minutes

Use lorazepam with caution in tāngata whaiora with respiratory depression, such as in the context of chronic obstructive pulmonary disease (COPD) or sleep apnoea.

Promethazine is contraindicated in tāngata whaiora who have taken monoamine oxidase inhibitors (MAOIs) within the last 14 days, with CNS depression of any cause, and jaundice induced by other phenothiazine derivatives.

For antipsychotic oral monotherapy, recommendations include:

Antipsychotic Medication	Dose	Maximum dose in 24 hours	Consider repeat dosing not before:
*Haloperidol**	2mg – 5mg	10mg	120 minutes
Olanzapine	5mg – 10mg	20mg	120 minutes
Quetiapine	25mg – 200mg	750mg	120 minutes
*Risperidone**	1mg – 2mg	4mg	120 minutes

*Please ensure PRN benzatropine or procyclidine are available for use with first generation anti-psychotics or risperidone. Benzatropine maximum dose in 24 hours is 6mg, procyclidine maximum dose in 24 hours is 60mg.

2.4.3 Level Three: Oral Combinations

If there is inadequate response to oral monotherapy consider oral combinations. These combinations include one of the above antipsychotic medications with one of the above sedative medications. Examples of combinations are:

- Lorazepam + olanzapine
- Promethazine + haloperidol

2.4.4 Level Four: Intramuscular Monotherapy

If oral monotherapy and combination therapy is refused or does not provide an adequate response, consider intramuscular monotherapy using the medications discussed above.

2.4.5 Level Five: Intramuscular Combinations

If there is inadequate response or a tāngata whaiora remains highly agitated, consider combining sedative and antipsychotic medication and administering simultaneously.

Combinations of Intramuscular treatment:

- Haloperidol 5mg – 10mg & promethazine 25mg - 50mg
- Haloperidol 5mg – 10mg & lorazepam 1mg – 2mg

Note: Olanzapine and lorazepam should not be administered simultaneously due to the risk of hypotension, bradycardia, bradypnoea, and/or oxygen desaturation. However if they are administered at least 60minutes apart the risk of these effects is significantly reduced.

2.4.6 Level Six: Monitor and review

Monitor physical observations and response to treatment. At all levels, ensure there is a minimum of one hour of 10/60 physical and mental health observations, that is observation every ten minutes for at least 60 minutes. Further monitoring beyond 1 hour should be considered if deemed clinically appropriate or in response to a change in clinical condition.

For all interventions at level 4 or above (intramuscular treatment), monitor physical observations after 60 minutes, and then every 4 hours for at least 12-24 hours.

Physical observations required include:

- Blood pressure
- Pulse
- Respiratory Rate
- Level of consciousness
- Temperature
- Hydration

Appropriate sedation monitoring and side-effect assessment should be performed regularly after administration based on the clinical condition of the tāngata whaiora and documented on the Adult Vital Signs chart.

If the tāngata whaiora is over-sedated or significantly unwell, the use of pulse oximetry to continuously measure oxygen saturation should be used.

Any deviations from monitoring parameters must be reported immediately to medical staff.

After administration of zuclopenthixol-acetate (Acuphase), monitor physical observations as above, noting the peak of sedation may take several hours after the dose is administered.

For inadequate response to level five of this guideline (intramuscular combinations), seek senior medical advice for a comprehensive case review. It is also appropriate to consider zuclopenthixol acetate (Acuphase). This medication requires consultant authorisation, and must be prescribed alongside benzatropine or procyclidine. Doses of zuclopenthixol acetate are as follows:

- Zuclopenthixol acetate 50mg – 150mg IM
- Dose can be repeated after 24 hours
- Total dose not to exceed 400mg or 4 injections within 14 days.
- All other antipsychotic and sedative medication should be stopped.

Another option to consider is ECT, however this should be considered with senior medical advice.

If the tāngata whaiora is unable to tolerate monitoring, document this clearly, and hold a low threshold for escalating medical concerns.

2.5 Precautions

Precaution	Action
Adolescents under 16yo, or those with low body weights (e.g. less than 40kg).	May need smaller doses Contact the child and adolescent psychiatrist during working hours for further advice. ICAMHS Duty Clinician phone 021356431
Older adults (60 years and over)	May require lower doses (half or quarter) due to reduced organ function and or medical illness/frailty. For further advice, contact the mental health services for older person's consultant psychiatrist via the hospital operator during working hours.
Pregnant women	Use lowest possible dose for efficacy • Oral diazepam 5mg/dose up to a maximum of 15mg daily • IM Olanzapine 5mg/dose PRN up to maximum of 20mg If higher doses are required, contact the on-call consultant psychiatrist. For further advice during working hours, contact consultation liaison psychiatry, or a perinatal consultant.
Medical illness	Avoid tranquilisation where behavioural disturbance is likely secondary to a serious medical condition for which there is specific emergency treatment such as: • hypoglycaemic crisis or • hypoxia due to acute asthma
Respiratory Depression	Recommend increased frequency of EWS monitoring. Caution with administering medication that exacerbates

	respiratory depression. Consider dose reduction, or utilising alternative medication instead.
Intellectual impairment or acquired brain injury	Can be very sensitive to pharmacological sedation and high drug doses should be avoided. Consider dose reduction (half or quarter dose).
Substance withdrawal	Longer acting diazepam is preferred to shorter acting benzodiazepines. In the context of hepatic impairment, consider using a benzodiazepine that bypasses hepatic metabolism consider using a benzodiazepine with a short half-life. Thiamine should also be prescribed for alcohol withdrawal. See the Te Whatu Ora Waikato Guidelines for alcohol withdrawal (2672) for further information.
Obesity	The efficacy of antipsychotic and sedative medications on this guideline is not affected by weight, and thus elevated weight should have no impact on decision making.
Swallowing problems	Heavy sedation (especially with antipsychotics) or delirium is associated with increased risk of aspiration. In tāngata whaiora with dysphagia, prescribe cautiously.
Delirium	Unless the delirium is caused by alcohol, avoid benzodiazepine treatment.
History of neuroleptic malignant syndrome	Use sedative options by preference. If antipsychotic use is necessary, consider using quetiapine.
Markedly intoxicated, dehydrated, antipsychotic (neuroleptic) naïve, medically compromised.	Reduce to half the recommended dosage.
Concomitant administration of IM olanzapine and parental benzodiazepines.	Not to be administered within 1 hour of each other

2.6 Adverse Drug Reactions

Side-Effect	Medication Association	Management
Respiratory depression	Benzodiazepines, Olanzapine. Increased risk with tāngata whaiora who are prescribed medications which cause hypoventilation, such as opioids.	If caused by benzodiazepine, is reversible with flumazenil. Avoid flumazenil in comorbid seizure disorder. Consider intensive respiratory support.
Extrapyramidal reactions	Common with droperidol and haloperidol, less	Benzatropine 1-2mg IM Procyclidine 5-10mg IM

	common with olanzapine, risperidone, quetiapine.	
Neuroleptic malignant syndrome	Seen with antipsychotics	Stop all antipsychotics and commence supportive care
Paradoxical reactions	Benzodiazepines and promethazine have rarely been associated with in increased agitation and anxiety.	Caution in high risk groups, consider PO rather than IM use. Consider giving using an antipsychotic instead.

Report all significant ADRs to CARM: https://nzphvc.otago.ac.nz/

3 Audit

3.1 Documentation

For all tāngata whaiora requiring management of acute behavioural disturbance, assessment, monitoring, and interventions should all be recorded in the clinical notes.

3.2 Future Audits

Practitioners carrying out pharmacological management may be subject to audit of administration and compliance with local guidelines. These audited outcomes and any complications should inform ongoing training, education, and support of all team members involved in the care of tāngata whaiora who receive pharmacological management of acute behavioural disturbance.

Regular local review of incidents should occur to identify common issues and quality improvement opportunities.

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4.2 Associated Te Whatu Ora Waikato Documents

- Alcohol Withdrawal guideline (Ref. 2672)
- Prevention, Diagnosis and Management of Delirium in Older People guideline (Ref. 1106).
- Informed Consent policy (Ref. 1969)
- Medicines Management policy (Ref. 0138)
- Resuscitation policy (Ref. 1970)
- Mental Health and Addictions Advance Directives procedure (Ref. 2181)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (Ref. 5238)
- Mental Health and Addictions Use of Seclusion in Mental Health and Addiction Inpatient Setting procedure (Ref. 1860)
- Mental Health and Addictions Use of Personal Restraint across Mental Health and Addictions Inpatients Settings, inclusive of OPR1 procedure (Ref. 1865)

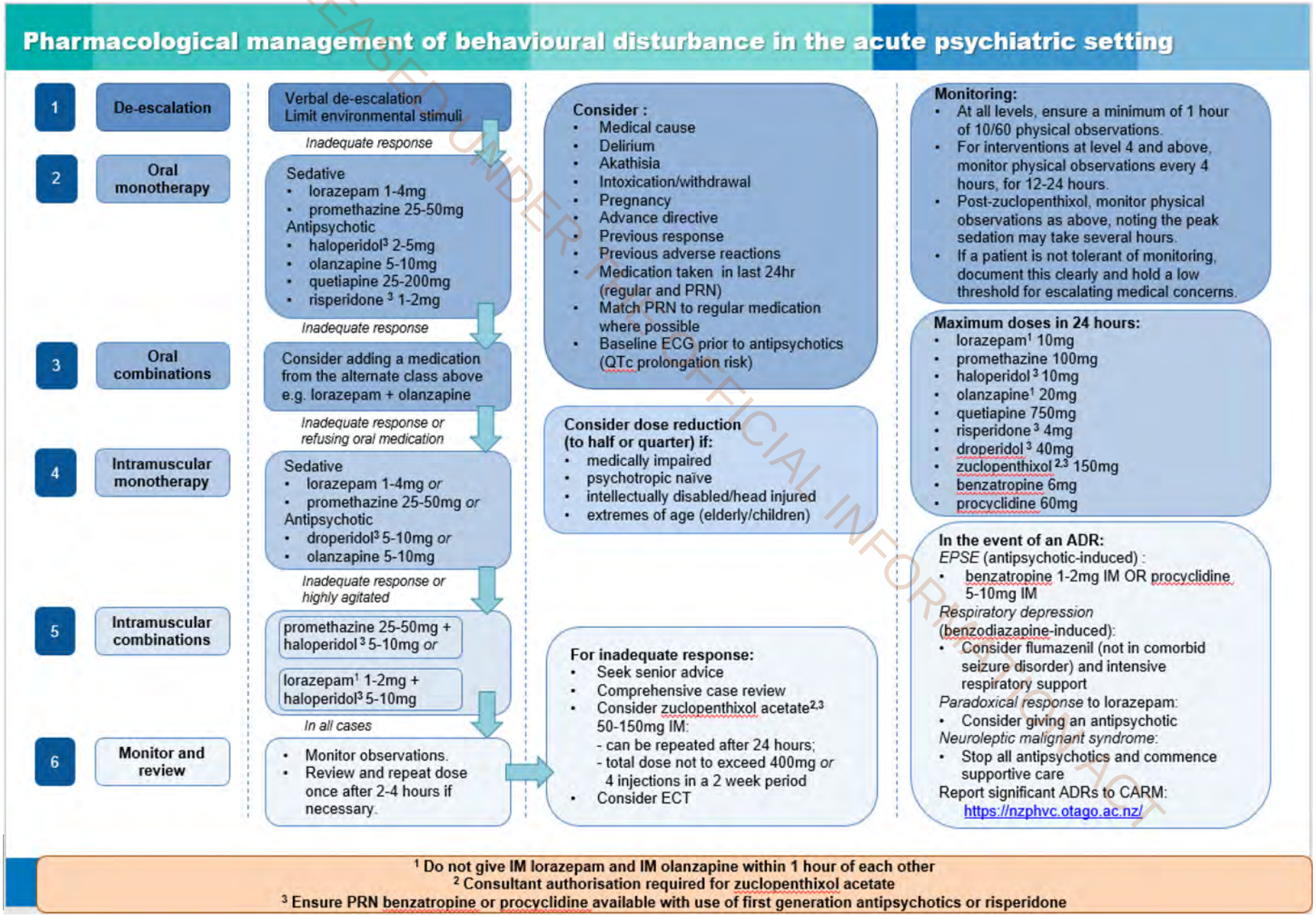
Appendix A

See diagram for pharmacological management of behavioural disturbance in the acute – psychiatric setting on page 15

Te Whatu Ora
Health New Zealand
Waikato

Guideline

Pharmacological Management of Behavioural Disturbance in the Acute Psychiatric Setting



Waikato District Health Board

Procedure

Professional Supervision for Registered / Enrolled Nurses in the Mental Health and Addictions Service

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Carole Kennedy
Document Facilitator Title	Nurse Director
Document Owner Name	Clinical Services Director
Document Owner Title	Rees Tapsell
Target Audience	Mental Health and Addictions
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
2	Moira O'Shea	December 2014	20/7/ 15 removal of (5) spelling in Action 5, page 7 inclusion re video link, - page 4 , Procedure action , included "annual performance reviews' – page 6
2	Carole Kennedy	16/07/2015	Removal of clinical from nurse director title Inclusion of supervisee accessing supervision outside of their environment.
3	Carole Kennedy	04/01/2019	Version due for update

Professional Supervision for Registered / Enrolled Nurses in the Mental Health and Addictions Service

Contents

Professional Supervision for Registered / Enrolled Nurses in the Mental Health and Addictions Service

1 Overview

1.1 Purpose

Professional supervision is an essential component of nursing practice in the mental health and addictions services. Professional supervision supports every registered / enrolled nurse working in partnership with service users / tāngata whaiora and their families / whānau. This formal process provides the opportunity to actively reflect on one's clinical practice, and develop one's knowledge in contemporary mental health and addictions practice. Embedding "Let's get Real skills" seven skills into ones nursing practice becomes an enabler to support service user tāngata whaiora outcomes, as supervision is the vehicle that brings about positive change.

Professional supervision encompasses all of the values and behaviours of the six (6) 'C's: Care, compassion, competence, communication, courage and commitment leading to better experiences and better outcomes for both the registered / enrolled nurse and the service user / tāngata whaiora / whānau.

1.2 Scope

This procedure applies to all registered / enrolled nurses employed in mental health and addictions service with a current annual practicing certificate (APC) Nursing Council of New Zealand; in accordance with the Health Practitioners Competence Assurance Act 2003.

1.3 Exceptions / contraindications

This procedure applies to all registered/enrolled nurses.

1.4 Definitions

Professional Supervision	Professional "supervision involves a formal relationship in which a nurse discusses the nursing experiences with a more experienced nurse to foster the development of self-assessment and analytical and reflective skills, provide support, and promote patient safety and nurse accountability" (Ashley & Karahashian, 2018).
Cultural Supervision	"It is a formal supervision relationship that has as its purpose the enhancement of awareness, knowledge and skills for working with and within the cultural context of tāngata whaiora. Cultural supervision may be provided in addition to clinical or professional if this is required to support practitioners to improve their knowledge of cultural values, manage complex cultural issues and to ensure safe practice and culturally appropriate behaviour" (Te Pou o Te Whakaaro Nui 2015).

2 Clinical Management

2.1 Competency required

All supervisors will have 2 years post-entry into mental health and addictions clinical practice, have completed an approved course of supervision training or equivalent and be approved by the nurse director.

All supervisors are required to complete 2 yearly updates facilitated by approved educators to maintain their function as a supervisor.

All supervisors and supervisees are required to ensure supervision agreements are renewed annually and lodged with the nurse director's administration support.

There is an expectation that all newly trained supervisors must be engaged in providing supervision within 2 months of completing their training to ensure their new skills are embedded into practice.

This link has all available supervisors and is updated at least 3 times a year, post completion of supervision training.

https://intranet.sharepoint.waikato.health.govt.nz/RefDocs/Mental%20Health/Trained%20Supervisors.pdf

2.2 Equipment

Electronic Database – trained supervisors and agreements are maintained by the mental health and addictions corporate administrators on behalf of the nurse director.

Professional supervision notes and attendance are maintained by the supervisor and supervisee, stored electronically and password protected, by use of the Waikato DHB log in process.

2.3 Procedure

1. Action:

Every registered / enrolled nurse employed in the mental health and addictions service is required to participate in regular professional supervision and evidence this at their annual performance reviews. This may take the form of individual or group supervision for registered / enrolled nurses.

Receiving supervision requires a supervisee to identify a supervisor external to the same team or unit environment.

All forms of professional supervision require a professional supervision agreement and log record that is electronically stored.

All registered / enrolled nurses must be engaged in one form of professional supervision as listed in this procedure, there are no exceptions.

Rationale

Professional supervision encourages learning, expansion of practice skills, self-assessment and exercise of analytical and reflective skills; cultural responsiveness and safety, appropriate use of models, and linking practice to cultural knowledge. One on one

supervision external to the supervisee's team is to ensure there is objectivity when discussing ethics and boundaries so that confidentiality is not compromised. For example, South and North Rural Sectors clinicians would be supported to use acceptable video conferencing opportunities, or travel outside of their area within the Waikato DHB region, endorsed by the line manager.

2. Action:

Styles of delivery of Professional supervision

1:1 (supervisor and supervisee) provided by a registered / enrolled nurse trained in professional supervision external to the supervisee's team but with mental health and addictions experience.

1:1 (supervisor and supervisee) provided by a supervision-trained health professional who is not a registered / enrolled nurse. This form of supervision must be negotiated by the supervisee, with the nurse director and respective professional advisor.

Group supervision – supervisor led, with supervisees provided by a registered / enrolled nurse who has completed the supervision training and is skilled in group facilitation. The number in the group is determined by the supervisor.

External to the organisation - professional supervision requires a discussion with the nurse director / line manager in the first instance. Professional supervision that requires the supervisee or supervisor to travel unreasonable distance within Waikato DHB region must have the approval of the charge nurse manager / team leader.

Professional supervision agreement

This is a written agreement between the supervisee and the supervisor which outlines the expectations of the roles of supervisee and supervisor. Both parties have responsibilities for ensuring the frequency of the sessions, attendance and both actively engaging in the session. The agreement outlines the terms of the contract. Appendix1

All original agreements and associated information will be held by the nurse director e.g. supervisor database, qualifications and training updates. This data base is kept up to date by the mental health corporate administrators. The supervisee will receive notification when the contract is about to expire.

All agreements are reviewed and updated annually PRIOR to EXPIRY date by the supervisor / supervisee, and sent to the nurse director. It is strongly recommended to change supervisor / supervisee at least 3 yearly.

When an agreement terminates it is the responsibility of the supervisor and supervisee to inform the nurse director and respective charge nurse manager / team leader.

It is expected that attendance records and brief notes on content are electronically maintained by supervisor/supervisee.

It is recommended that one hour of each type of professional supervision be available per month for full time registered / enrolled nurses (pro rata for part time registered/enrolled nurse). It is expected that registered / enrolled nurses aim to attend a minimum of 8 sessions per annum.

Rationale

Professional supervision establishes boundaries around the relationship between the practitioner, service user / tāngata whaiora, family / whānau and support agencies. This results in effective treatment outcomes.

The value of professional supervision enhances one's confidence, increases analytical and reflective skills to work with service users /t āngata whaiora. Facilitates the retention of mental health and addiction nurses and brings about professional satisfaction in their workplace.

Action:

A written professional supervision agreement will be established within 2 sessions of supervision commencing, between the supervisor and supervisee, including:

- Frequency and time of meetings
- Location
- Responsibilities / expectations including pre-session preparation
- Review process and termination date of supervision agreement
- Professional supervisor's own professional supervision arrangements to be noted
- Boundaries of confidentiality

Supervisee and supervisor will retain a copy of the agreement. Copies are provided to the nurse director and line manager.

Recording and documentation

- Is a requirement for "potential ethical and legal responsibilities of the organisation, supervisor and supervisee". The content would include supervisee's caseload numbers (if appropriate). A brief overview of the supervisory discussion, supervisee learning and developmental needs; any significant issues and appointment changes.
(Te Pou o Te Whakaaro Nui (2017) *Te Tirohanga a te Manu: "A bird's perspective" Professional supervision guide for nursing leaders and managers.* Auckland: Te Pou o te Whakaaro Nui pg. 23)

Rationale

Engagement in professional supervision requires endorsement from the line manager, for release from clinical practice to attend the sessions. The line manager is responsible for professional matrix and it is expected that this allocated time is used effectively and efficiently, and evidence of attendance may be required.

3. Action:

Confidentiality

Professional supervision discussion between the supervisee and the supervisor is deemed confidential with the exception of the following points.

- Mutually agreed information that is required to be included in the supervisee's annual performance review and development plan
- Evidence of professional supervision contract electronically uploaded on to Professional development recognition programme (PDRP).
- When concerns are raised within the supervision session these are discussed and identified the appropriate course of action

- Where the supervisor feels there has been a serious breach of the supervisee's ethical / legal and regulatory responsibilities. i.e. Code of conduct, breach of nursing council competencies/ professional standards/ Waikato DHB policies and procedures.
- There is a risk of serious emotional / physical harm to the service user / tāngata whaiora, supervisee, supervisor or to others, having discussed this with the supervisee.
- If disclosure of confidential information is required, this will be in partnership with the supervisee / supervisor, nurse director and the leadership team.
- Information is required by legal intervention i.e. subpoena by courts

Rationale

Professional supervision is an essential component of nursing practice in the mental health and addictions service, supported by the respective line manager. The performance review provides the opportunity to demonstrate one's individual growth and identify developmental plans to support the registered / enrolled nurse in clinical practice.

The principle purpose of the Health Practitioners Competence Assurance Act 2003 is to protect the health and safety of members of the public by providing ways to ensure that all health practitioners are competent and fit to practice.
New Zealand Ministry of Health. (2003) Health Practitioners Competence Assurance Act (2003). For the protection and safety of person(s) or public from self-harm or danger to others.

4. Action:

The nurse director will arrange for:

- Electronically stored professional supervision agreements
- Maintenance of a current register of registered / enrolled nurses trained in professional supervision. Link provided above.
- The support and selection of registered / enrolled nurses for ongoing and new training requirements

Rationale

Effective and efficient maintenance of current supervisor database that is accessible to staff.

5. Action:

Professional supervision will be provided from registered / enrolled nurses within the mental health and addictions service unless there are specific needs that cannot be met within the service.

Rationale

Resource issues are managed appropriately.

3 Audit

3.1 Indicators

All registered / enrolled nurses working in the mental health and addictions service are engaged in regular, high quality professional supervision; attendance will be recorded in performance reviews.

Reminders are generated to ensure all supervision contracts are up to date

3.2 Tools

Yearly audit of professional supervision database and performance reviews.

4 Evidence base

4.1 Summary of Evidence, Review and Recommendations

Legislative Requirements:

Health Practitioners Competency Assurance Act 2003

4.2 References

Associated Documents

- Mental health and addictions Workforce Action Plan 2017 - 2021 https://intranet.sharepoint.waikato.health.govt.nz/RefDocs/Mental%20Health/MHAS%20Strategic%20Plan.pdf
- Professional and group supervision contract for registered / enrolled nurses in mental health and addictions
- Professional supervision record log for registered / enrolled nurses in mental health and addictions. https://intranet.sharepoint.waikato.health.govt.nz/Pages/Mental%20Health/Mental%20health%20nursing.aspx
- Waikato DHB Information Privacy policy 1976 https://intranet.sharepoint.waikato.health.govt.nz/site/pol/published/Information%20Privacy.pdf
- Waikato DHB Managing Behaviour and Performance policy 5250 https://intranet.sharepoint.waikato.health.govt.nz/site/pol/published/Managing%20Behaviour%20and%20Performance.pdf

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- Te Pou o Te Whakaaro Nui (2017) *Te Tirohanga a te Manu: "A bird's perspective" Professional supervision guide for nursing leaders and managers.* Auckland: Te Pou o te Whakaaro Nui https://www.tepou.co.nz/uploads/files/TP%20Prof%20Supervision%20-%20Leaders%20-%20v9%20-%20Final_web-2.pdf

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New Zealand Ministry of Health. (2003) Health Practitioners Competence Assurance Act 2003. Retrieved from http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Waikato District Health Board

MENTAL HEALTH AND ADDICTIONS SERVICE

Individual supervision agreement for registered nurses

Supervisee _____ Clinical Area _____

Supervisor _____ Clinical Area _____

Date:_____

☐ 1:1 (supervisor and supervisee)

A written professional supervision agreement will be established within two sessions from commencement and the supervisee and supervisor will retain a copy of the agreement. The original MUST be supplied to the nurse director.

The terms of the contract are as follows:

1. It is expected the relationship will be collegial, respectful, collaborative and honest in accordance with Nursing Council New Zealand competencies.
2. All information discussed is CONFIDENTIAL to the supervisor/supervisee with the exception of:
   a. mutually agreed information that is required to be included in the supervisee's annual performance review by their charge nurse manager/ team leader.
   b. where the supervisor feels there has been a serious breach of the supervisees ethical/legal and regulatory responsibilities, OR that there is a risk of serious emotional/physical harm to the service user/tangatata whaiora, supervisee, supervisor or to others. The onus is on the supervisor to notify the supervisee's charge nurse manager/ team leader and nurse director of this view, having discussed this with the supervisee.
   c. Information is required by legal intervention, i.e. subpoena by courts
   d. Information is passed on as required by verbal and written service user/tangata whaiora consent.
3. The contract is valid for one year only and a new contract will be made if it is agreed that the supervision will continue. (It is recommended that supervisory arrangements should be changed every three years maximum).
4. That the supervisor will be engaged in professional supervision and may take any material to their own supervisor for discussion.
5. That the supervisor and supervisee prepare for the session.
6. That the supervisor and supervisee will negotiate attendance at the supervision sessions with their respective charge nurse manager/ team leader.
7. That the supervisor will maintain a record log of the sessions and store electronically password protected with supervisor/supervisee's Waikato DHB log ins.
8. That supervision sessions will take place monthly for at least one hour at an agreed time and easily accessible venue or via technological support – ie Jabber
9. Any other reasonable terms as determined by the professional supervisor and supervisee.

_____

_____

_____

_____

_____

Signature of supervisor:_____ Date:_____
dd/mm/yy

Signature of supervisee:_____ Date:_____
55/mm/yy

Contract expiry date:_____

Send copy to:
Supervisor ☐
Charge nurse manager/Team leader ☐
Nurse director ☐

Office use only:
Date entered on people soft:_____

Waikato District Health Board

MENTAL HEALTH AND ADDICTIONS SERVICE

Group supervision agreement for registered nurses

Supervisee _____ Clinical Area _____

Supervisor _____ Clinical Area _____

Date:_____

☐ 1:2 (supervisor and supervisees)

A written professional supervision agreement will be established within two sessions from commencement and the supervisee and supervisor will retain a copy of the agreement. The original MUST be supplied to the nurse director.

The terms of the contract are as follows:

1. It is expected the relationship will be collegial, respectful, collaborative and honest in accordance with Nursing Council New Zealand competencies.
2. Group dynamic rules, considerations and responsibilities as group members will be explored and agreed upon. For example confidentiality amongst participants, consequences of breaches of trust and respect for one another
3. All information discussed is CONFIDENTIAL to the supervisor/supervisee with the exception of:
   a. mutually agreed information that is required to be included in the supervisee's annual performance review by their charge nurse manager/ team leader.
   b. where the supervisor feels there has been a serious breach of the supervisees ethical/legal and regulatory responsibilities, OR that there is a risk of serious emotional/physical harm to the service user/tangatata whaiora, supervisee, supervisor or to others. The onus is on the supervisor to notify the supervisee's charge nurse manager/ team leader and nurse director of this view, having discussed this with the supervisee.
   c. Information is required by legal intervention, i.e. subpoena by courts
   d. Information is passed on as required by verbal and written service user/tangata whaiora consent.
4. The contract is valid for one year only and a new contract will be made if it is agreed that the supervision will continue. (It is recommended that supervisory arrangements should be changed every three years maximum).
5. That the supervisor will be engaged in professional supervision and may take any material to their own supervisor for discussion.
6. That the supervisor and supervisee prepare for the session.
7. That the supervisor and supervisee will negotiate attendance at the supervision sessions with their respective charge nurse manager/ team leader.
8. That the supervisor will maintain a record log of the sessions and store electronically password protected with supervisor/supervisee's Waikato DHB log ins.
9. That supervision sessions will take place monthly for at least one hour at an agreed time and easily accessible venue or via technological support – ie Jabber
10. Any other reasonable terms as determined by the professional supervisor and supervisee.

_____
_____
_____
_____
_____
_____

Signature of supervisor:_____ Date:_____
dd/mm/yy

Signature of supervisee:_____ Date:_____
55/mm/yy

Contract expiry date:_____

Send copy to:
Supervisor ☐
Charge nurse manager/Team leader ☐
Nurse director ☐

Office use only:
Date entered on people soft:_____

Appendix 2:

Nursing Professional supervision or practice review Record Log

Nurse (Supervisee) …… ……. Clinical Area ……Ward ……
Clinical Supervisor …… Clinical Area … ……
Date: ….
Form: (please circle) **1:1** (supervisor & supervisee) or **Group 1:2+** (supervisor & supervisees)

Nursing Professional supervision or practice review Record Log to be maintained by the clinical supervisor and to be stored safely. The Nurse (supervisee) may also use the format for recording purposes.

Date & Time	Brief notes	Outcomes

Date & Time	Brief notes	Outcomes

Appendix 2:

Nursing Professional Group supervision or practice review Record Log

Nurse (Supervisee) …… ……. Clinical Area ……Ward ……
Clinical Supervisor ……
Clinical Area … ……
Date: ….
Form: **Group 1:2+** (supervisor & supervisees)

Nursing Professional supervision or practice review Record Log to be maintained by the clinical supervisor and to be stored safely. The Nurse (supervisee) may also use the format for recording purposes.

Date & Time	Brief notes	Group dynamic issues	Outcomes

Date & Time	Brief notes	Group dynamic issues	Outcomes

Puawai Internal Security

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff working in the Puawai inpatient services, contractors, and visitors
Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.	

Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
02	Kylie Balzer	8 June 2018	RESPECT changed to SPEC Visitor wrist bands changed to Visitor Identification tags Roles and responsibilities added
02	Areann Libline	8 February 2019	Detail relating to security responsibilities
03	Alan Barlow and Kylie Balzer	Updated March 2021	Changes made to action 3 under Issue and Collection of tāngata whaiora razors Feedback incorporated from consultation on cultural sensitivity for visitors Update to section on internal access corridor
	Kylie Balzer	February 2022	Document altered into current required format by the Quality and Patient Safety service. Changes made to highlight that only electric razors are permitted in the Puawai inpatient service Definition for wanded / wanding added

Puawai Internal Security

Contents

Puawai Internal Security

1 Overview

1.1 Purpose

The associated risks of a medium secure service require that the units adhere to the procedures deemed necessary in ensuring the integrity and safety of the environment for tāngata whaiora and staff.

The following procedures need to be adhered to:

a. Issue and collection of tāngata whaiora electric razors

b. Cutlery

c. Unit visitors

d. General ward search

1.2 Scope

This procedure applies to the Puawai inpatient wards at Waikato DHB and to all staff, contractors and visitors to the unit.

1.3 Patient / client group

Inpatient tāngata whaiora and unit visitors of the Puawai inpatient service.

1.4 Exceptions / contraindications

Electric Razors: A sign out process for electric razors is not required in Puna Taunaki. In Puna Whiti tāngata whaiora hold their own electric razors.

Cutlery: Puna Taunaki and Puna Whiti are excluded from the cutlery processes.

1.5 Definitions and acronyms

Wanded / Wanding	Use of a hand held metal detector for security check

SPEC	Safe Practice and Effective Communication Training
CWS	Clinical Work Station

2 Clinical management

2.1 Roles and responsibilities

All Staff with the Puawai service are to be aware of and follow this procedure

Charge Nurse Mangers / Associate Charge Nurse Managers are to monitor and manage the application of this procedure

Contractors must follow the requirements of this procedure

Security staff are to meet the competencies in relation to service requirements for visitors to the Puawai service

All staff, including security staff and visitors must adhere to the prohibited items list as described in the Visiting Puawai inpatient forensic service – A visitors guide (C1337HWF)

2.2 Competency required

Staff working within the Puawai service will receive information on the processes to follow for internal security as a component of their orientation programme and will be observed for competency in following these.

Security staff will receive education on service requirements for unit visitors as part of orientation to their role within the Puawai service and will be observed for competency in following these.

Non-Puawai staff entering the Puawai service will be provided with instructions on how to use the Duress alarm.

2.3 Equipment

- Documentation for recording electric razor allocation and return
- Locked cupboards for electric razors and cutlery
- Sharps containers
- Incident management system (DATIX)
- Board for documenting cutlery
- Metal detector (wand)
- Visitor identification tags
- Duress alarms
- Orientation programmes
- Visiting Puawai inpatient forensics service – A visitors guide (C1337HWF)
- Radio transmitter

2.4 Procedure

a. Issue and collection of tāngata whaiora electric razors

Note: only electric razors are permitted to be used in the Puawai inpatient service

1. All electric razors must be kept on the ward in a designated locked cupboard or container to enable ease of monitoring. There will be no more than one electric razor per tāngata whaiora. This includes personal razors in current use.

2. Electric razors are to be signed out by staff / allocated security person (excluding Puna Taunaki). It is the responsibility of the issuing staff member to ensure that all electric razors are returned intact and signed back in.

   In Puna Maatai staff must observe the tāngata whaiora while using the electric razor at all times.

   In Puna Whiti tāngata whaiora hold their own electric razors.

3. Tāngata whaiora who use electric razors. Each tāngata whaiora has their own removable electric razor head. Upon return of the electric razor, the head will be removed and placed in the security cabinet under the tāngata whaiora name to ensure that the head and cutters are not shared. If the head and cutters require replacing, it will be disposed of in the sharps box. A replacement head and cutters will be issued.

4. If an electric razor/or part of is missing the Charge Nurse Manager / Associate Charge Nurse Manager / shift coordinator will be notified immediately. A ward search may need to be initiated to locate the electric razor / parts whereabouts. Every effort should be made to locate the lost electric razor / part due to the serious risk of compromising tāngata whaiora and staff safety. If not found an incident form is to be completed in DATIX.

b. Cutlery

Excluding Puna Taunaki / Puna Whiti

1. An allocated staff member / allocated security person is designated the duty of 'cutlery' by the co-ordinator of each shift:
   - There will be a count of all cutlery prior to tāngata whaiora entering the dining room
   - The allocated staff member will ensure that the cutlery handed out and returned is recorded on the cutlery board against the tāngata whaiora name
   - Once all cutlery is returned to the allocated staff member and placed in the cutlery container the final check will take place in the kitchen

2. If the cutlery count is incorrect then all tāngata whaiora are to remain in the dining room (day room Puna Poi Poi). The Charge Nurse Manager / Associate Charge Nurse Manager / Coordinator will be notified immediately.

   The metal detector (wand) may be utilised. The tāngata whaiora may be searched in accordance with the Mental Health and Addictions Searching of Mental Health tāngata whaiora in relation to an illicit substances / dangerous articles policy (1862). ***If the cutlery is not recovered an incident form is to be completed in DATIX.***

3. Cutlery is to be kept in the locked cupboard when not in use to prevent items being misplaced and / or moved.

c. Unit visitors (Non Puawai staff and or visitors)

Excluding Puna Taunaki / Puna Whiti from Number 2 in this section.

1. All visitors to the unit must be authorised by one of the following people:

   Charge Nurse Manager, Associate Charge Nurse Manager, Senior nursing staff on shift, Director / Operations manager of the service. Staff must be made aware of non-Puawai staff and / or visitors who enter the units to ensure:

   - To ensure the security of the ward remains intact and knowledge of non-Puawai staff and or visitors presence on the units
   - Non-Puawai staff may not be SPEC trained or possess knowledge of how to remain safe on the ward
   - To ensure the safety, privacy and confidentiality of Puawai tāngata whaiora

2. All visiting WDHB non-Puawai staff, Puawai staff, contractors, and / or visitors will enter via the security booth (except in Puna Taunaki and Puna Whiti).

   Entrance via the internal access onto the corridor (level 2 access onto Puna Maatai and Puna Awhi-rua) is used only in
   - Emergency situations
   - If using a trolley / wheelchair
   - Internal transfer of tāngata whaiora between Puna Maatai and Awhi-rua
   - Court personnel

   When responding to an emergency, there are two access fobs for responders to use, located in the internal lock. Security will monitor that the fobs are returned after the emergency has passed.

   Non-Puawai staff (includes adult inpatient service staff supporting tāngata whaiora using Puawai facilities)
   All non-Puawai staff must:
   - Hand their identification in at the security booth.
   - Sign the visitor's book on entry and exit to Puawai
   - Be issued with a visitor's identification tag and sign for a duress alarm.
   - Have security contact the ward and request a staff member to escort them
   - Be escorted onto the ward and during their visit unless other arrangements have
   - been arranged by senior nursing staff relating to the adult inpatient staff utilising Puawai facilities

   Contractors
   All contractors must
   - Sign the visitor's book on entry and exit to Puawai.
   - Be issued with a visitor's identification tag and sign for a duress alarm.
   - Have security contact the ward and request a staff member
   - Be escorted onto the ward and remain with them during their entire visit (some contractors may already have pre-arranged escorts).

Puawai staff

All Puawai staff (and those with both external and internal keys) must

- Hand their external keys and identification into security
- Obtain their internal keys and identification from security.
- Access their allocated duress alarm before entering the wards if working on level 2. For staff with external and internal keys, who are not Puawai staff, for example co-ordinators, quality improvement staff, a duress alarm must be issued by security and signed for.
- Have their internal keys, identification and duress securely attached to a lanyard or clothing at all times

After hours medical staff

All after hour's medical staff must:

- Hand their external keys and identification into security
- Be issued with internal keys and a visitors identification tag
- Sign for a duress alarm
- Sign the visitors book
- Can enter the wards without escort

Visitors

All tāngata whaiora visitors' must:

- Sign the visitor's book on entry and exit to Puawai
- Hand in items that are not allowed onto the units at security (as per visiting Puawai inpatient forensic services – a visitor's guide.)
- Be wanded before entering the ward. The wanding does not include the head area.
- Remove any head gear, hats, caps or bands unless head wraps are used for religious or medical reasons
- Run their fingers through their hair if long and unruly to ensure no contraband is concealed except in situations where this would be deemed culturally inappropriate
- Be issued with a visitor's identification tag and sign for a duress alarm.
- Have security contact the ward and request a staff member to escort them
- Be escorted to the Puawai visiting area and have a staff member with them throughout the visit
- Be escorted back to security once the visit is over

Key points:

- Ensure all persons entering the Puawai unit are cleared by security.
- Ensure any 'visitors' status is clearly visible
- Although visiting non-Puawai staff and / or visitors are escorted AT ALL TIMES while in the unit, the carrying of a duress alarm at all times is mandatory.

3. To maintain safety no whānau / friends / carers are to enter the ward except for whānau day or with prior approval by the Charge Nurse Manager / Associate Charge Nurse Manager or Operations Manager.
4. When notified (by security) that non-Puawai staff wish to access the unit, a staff member will proceed to security and escort them onto the unit.

   Non-Puawai staff and / or visitors need to be supervised AT ALL TIMES.

   Safety precautions will be put in place, e.g. ensuring that bedrooms are empty and the corridor area are locked off.

   Staff need to ensure that the safety of non-Puawai staff and / or visitors is maintained from the point of entry to exit.
5. If the purpose of the visit is a whānau visit then staff must have a radio transmitter and supervise the visit discreetly while observing the visit at all times to monitor:

   a) Tāngata whaiora mental state, behaviour, risk and

   b) Any possible breach in security (e.g. passing illicit substances) and

   c) Report and / or document the visit in CWS

   At completion of the visit the supervising staff member must radio transmit the unit to advise that the visit has ended and they require an escort for the visitors to be taken back to the security entrance.

   Staff are to maintain awareness at all times the need to maintain the safety and security of all individuals within the Puawai inpatient service.

d. General ward search

1. The tāngata whaiora will be informed that a ward search is to take place for a defined reason and what is being sought. This will provide an opportunity (amnesty) for the item to be returned prior to the search. Tāngata whaiora will be offered the opportunity to be present during the search of their personal property.

   An email will be sent to the District Inspector informing them of the wards search by senior nurse / delegate, and an incident form completed in DATIX.
2. Tāngata whaiora will be confined to a limited area of the ward under staff supervision whilst the rest of the ward is being searched. This will maintain the safety of searching staff and ensure the item is not secreted out of the area. Once the area has been searched then the tāngata whaiora can return to that area.
3. Tāngata whaiora are to be informed when the search is complete and thanked for their cooperation.

   If appropriate the Charge Nurse Manger / Associate Charge Nurse Manager / shift coordinator will inform the tāngata whaiora of the outcome of the search and address any issues that require discussion with them.

   An opportunity for discussion can be provided for the tāngata whaiora if a need is identified. Tāngata whaiora have the right to be informed of outcomes and any

issues of concern should be addressed in a clear manner encouraging communication and maintenance of rapport.

If a banned or dangerous item is found it will be immediately confiscated and all relevant information recorded in the tāngata whaiora clinical record and all relevant documentation competed (an incident form must always be completed in DATIX for all ward searches regardless of whether items are found or not and an email sent to the District Inspector). The incident form will be followed up by the Charge Nurse Manager / Associate Charge Nurse Manager to identify any new hazards, and plans put in place to reduce any risks identified.

3 Patient information

Visiting Puawai inpatient forensics service – A visitors guide (C1337HWF)

4 Audit

4.1 Indicators

- Security checks
- Cutlery counts
- Level of observations
- DATIX incident reporting

4.2 Tools

- Audits of security checks, cutlery counts, and levels of observation
- Incident management

5 Evidence base

5.1 Associated Waikato DHB Documents

- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others protocol (Ref. 5241)
- Mental Health and Addictions Duress Alarm Use and Management in the Henry Rongomau Bennett Centre procedure (Ref. 2681)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (Ref. 5238)
- Mental Health and Addictions Searching of Mental Health service users in relation to illicit substances / dangerous articles procedure (Ref. 1862)
- Waikato DHB Clinical Records Management policy (Ref. 0182)
- Waikato DHB Incident Management policy (Ref. 0104)

5.2 External Standards

- Health and Disability Services Standards NZS 8134:2021
- Privacy Act 2020
- Misuse of Drugs Act 1975
- Crimes Act 1961
- Health and Disability Commission Consumer Rights Act 1994
- Mental Health (Compulsory Assessment and Treatment) Act 1992

Recovery Planning

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions Service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
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Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions Clinical Staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Kylie Balzer	Oct 2022	Changed into current Te Whatu Ora Waikato Guideline template, updated health literacy resource from HQSC, updated section on external standards, change from acute care recovery plan to inpatient recovery plan, update of audit indicators and tools. Addition made to exceptions section.

Recovery Planning

Contents

Recovery Planning

1 Overview

1.1 Purpose

The purpose of this guideline is to provide best practice information and expectations on the recovery planning process in the Mental Health and Addictions Service by all multidisciplinary team members.

1.2 Staff group

Clinical staff in the Mental Health and Addictions Service.

1.3 Patient / client group

Mental Health and Addictions tāngata whaiora.

1.4 Exceptions / contraindications

There may be occasions when tāngata whaiora subject to the Mental Health (Compulsory Assessment and Treatment) Act where not all components of the recovery plan are agreed by the tāngata whaiora often because they lack insight into their mental illness. The care plan in these circumstances may include working with the tāngata whaiora and whānau to improve understanding of their illness and relapse plan, and acknowledge some components of the plan of care are directed by the team and not mutually agreed.

1.5 Definitions and acronyms

Collaboration	Collaboration means working together with the tāngata whaiora and whānau to provide optimal care for the tāngata whaiora or tāngata whaiora group
Health literacy	Is being able to obtain, understand and use basic health information and be able to navigate health services and make appropriate decisions.
Inpatient recovery plan	The inpatient recovery plan is a document done in a collaborative way to support any acute episode of care.
Pacific influences in healthcare	While the diversity of Pacific people needs to be acknowledged there are some general perceptions about health i.e. a holistic notion of health and health as a family concern rather than an individual matter. It is important to consider also that there are differences between the beliefs of Pacific people born in New Zealand and those who are migrants. Reference document: Improving quality of care for pacific peoples. A paper for the Pacific Health and Disability action plan review. Ministry of Health, 2008.
Person centred care	Health and social care that is respectful of the needs, values and preferences of the person / people using the health care services and recognises the person's strengths.

Recovery	Health and social care that is respectful of the needs, values and preferences of the person / people using the health care services and recognises the person's strengths.
Tāngata whaiora self-initiated plan	A plan that is designed and managed by the tāngata whaiora to support their wellness / recovery
Te Whare Tapa Whā	A Māori view of health which includes four dimensions: Te Taha Whānau (social environment and whānau), Te Taha Wairua (spiritual), Te Taha Hinengaro (mental and emotional), and Te Taha Tinana (physical). These components are viewed holistically.
Wellbeing recovery plan	The recovery plan that is documented as part of the community / rehabilitation phase of the integrated care pathway

2 Clinical management

2.1 Roles and responsibilities

Clinicians
All clinical staff are responsible for participating in best practice recovery planning processes.

Keyworkers / primary nurses are responsible for monitoring the quality and progress of recovery plans for the tāngata whaiora within their caseloads.

Managers
Managers are responsible for monitoring the standards of recovery planning within the service and providing feedback and upskilling opportunities in relation to recovery planning processes.

2.2 Competency required

Registered health professionals and social workers eligible for registration are responsible for the management of health care provision.

Staff completing recovery plans are competent in the following skills:

- Formulation of SMARTA goals (specific, measureable, achievable, realistic, time framed, and agreed)
- Coaching in the development of a person centred recovery plan
- Involvement of whānau in recovery planning processes
- Culturally supportive practice
- Linking assessment information to recovery planning
- Health literacy and the use of positive language
- Identification of health and social care needs and strengths and promoting safety and positive risk taking
- Co-ordinating care across services

Training / coaching on recovery planning will be provided as a component of the orientation and ongoing professional development for clinical staff within the Mental Health and Addictions service. Staff may also choose to discuss recovery planning within their supervision and / or with their team leader / Charge Nurse Manager.

2.3 Equipment

Recovery plan template in the clinical workstation.

2.4 Guideline

2.4.1 Recovery plans are individualised, accurate and up to date

An up to date and dynamic / lived recovery plan will be in place for tāngata whaiora across the pathway of care. This may include:

- Inpatient care planning
- Wellbeing recovery planning

Inpatient care planning: The recovery plan identified as a component of any acute period of care whether this be an inpatient, short term acute pathway, or home-based treatment. This plan will include the short-term goals developed in collaboration with the tāngata whaiora which will support the tāngata whaiora to return to either their wellbeing recovery pathway in the community / rehabilitation journey or back to primary care.

The inpatient care plan is based on the needs identified from the assessment undertaken which identified the need for acute intervention. Transfer of care back to the wellbeing recovery pathway or primary care will be a focus of the inpatient care planning process.

The inpatient care plan will be updated at any time there is a change in the condition of the tāngata whaiora or as appropriate to tāngata whaiora needs. This should include strategies that work to reduce restrictive practices such as restraint and seclusion.

The inpatient team will contact the keyworker and whānau to get their perspective on the inpatient care plan.

The inpatient care plan is to be documented in the inpatient care plan template appropriate to the context of care (e.g. adult, MHSOP, Forensic) on the clinical workstation (CWS).

Wellbeing recovery planning: The plan of care which includes both short term and longer-term goals advancing the health and social care needs of the tāngata whaiora towards recovery. This plan is collaboratively developed with the tāngata whaiora, is person centred and of which the tāngata whaiora has ownership.

The wellbeing / recovery plan will be updated based on the current context of the tāngata whaiora or as appropriate to tāngata whaiora needs and within a minimum of 91 days.

The community / rehabilitation plan will have a focus on transfer of care back to primary care.

Recovery plan dimensions:

The recovery plan is person centred and considers the following dimensions of health and social care needs:

- Te Taha Whānau – social environment and whānau needs
- Te Taha Wairua – spiritual needs
- Te Taha Hinengaro – mental or emotional needs
- Te Taha Tinana – physical needs

Note: for tāngata whaiora of diverse cultural identification the above dimensions should be considered under the most appropriate headings for their culture e.g. pacific cultures may associate with specific pacific oriented beliefs / model of care.

Recovery plans will support the cultural needs of the tāngata whaiora and whānau members of choice. At all times the recovery plan will have an emphasis on hope, support, education, self-advocacy and connectedness. The recovery plan will have personal meaning for the tāngata whaiora by including the specific cultural needs and desires and include responsibility for actions.

Goals identified as a component of the recovery plan will be person centred and whānau inclusive, measurable, and promote the tāngata whaiora to take the next steps forward in their recovery journey. A strengths-based approach will be utilised in addition to the identification of any problems / barriers / risks in the development of goals and interventions to be concentrated on. Prioritisation of one or two goals at a time may be useful. The working document needs to be both meaningful and useful for the tāngata whaiora.

Any tāngata whaiora self-initiated recovery plan and advanced directives provided by the tāngata whaiora will be considered in the process of recovery planning.

The tāngata whaiora will be encouraged to take increasing personal responsibility through self-directed care. Recovery planning is a process of collaborative understanding and shared making of choices.

The goals identified will be based on the most appropriate dimensions as above for the tāngata whaiora at any particular interval in the recovery journey and need to be based on what is a priority for the tāngata whaiora and in ICAMHS, include what is a priority for the whānau. Effective care planning involves choosing fewer interventions based on what is of the most importance for the tāngata whaiora.

The time frame for completion of goals and interventions will be appropriate to the health and social needs of the tāngata whaiora.

The recovery plan will identify who is doing what, when they are doing it, and why (the goals). Responsibilities will be clearly identifiable and may change dependent on circumstances.

If a tāngata whaiora is too unwell / not developmentally able, or not wishing to be involved in the recovery planning process this should be documented in CWS and a recovery plan based on current treatment needs formulated. Agreed whānau of choice may be able to participate in the process. Where there is an advanced directive this

should be utilised to provide information on the tāngata whaiora preferences for treatment when they are unwell.

Evaluation of recovery plan goals and interventions will be documented in the progress notes on the clinical workstation (CWS). Celebration of achievement of goals will occur on an ongoing basis.

If the recovery plan is addressing the transition of the tāngata whaiora out of the service then consideration of the tāngata whaiora risks inherent in the transition process needs to be carefully thought out and planned.

2.4.2 Recovery plans provide information on the support / interventions required to achieve desired outcomes

All recovery plans will provide measurable interventions to be implemented to achieve the desired outcomes of the tāngata whaiora and where appropriate the whānau of choice.

A recovery plan will include cultural and best practice interventions based on the tāngata whaiora identified strengths and needs. The plan will be flexible and evaluated at each point of interaction with the tāngata whaiora and more formally during multidisciplinary reviews.

2.4.3 Recovery plans link the care to be provided within the multidisciplinary team and across the health system

Recovery plans will include care provision by members of the multidisciplinary team, and be concentrated on the tāngata whaiora journey across the health care system.

All members of the multidisciplinary team will have access to the recovery plan and the plan will be shared across the continuum of care as is appropriate and with tāngata whaiora consent.

Staff will be mindful that the practice of collaboration is an important process for communication with tāngata whaiora and within the multidisciplinary team. Recovery involves developing good working relationships and a commitment to a culture of recovery-oriented practice.

Tāngata whaiora risks will inform the recovery plan.

2.4.4 Recovery plans identify early warning signs and interventions

The wellbeing recovery plan will include early warnings signs, stressors / triggers and person centred information on interventions to promote wellness and recovery. It will also include strategies for tāngata whaiora and whānau to proactively manage crises early on and that will guide clinician's responses when proactively supporting tāngata whaiora during crises.

The tāngata whaiora will be encouraged to share their early warning signs and stressors / triggers with members of their identified health care team i.e. whānau and service providers.

2.4.5 Recovery plans are developed in partnership with the tāngata whaiora, the provider of services, and the whānau as appropriate

The tāngata whaiora will be at the centre of the recovery planning process. Tāngata whaiora will be supported to lead and update their own recovery plans whenever practical, to participate in their evaluation, and be involved in multidisciplinary team meetings as appropriate to their care.

Methods of participation in the recovery planning process will be appropriate to the skills, developmental stage, needs, and wishes of the tāngata whaiora. Tāngata whaiora may choose to provide their own copy of a self-initiated recovery plan and advance directives which can contribute to the development of the recovery plan.

It is encouraged that the recovery plan will include the tāngata whaiora and whānau own words and phrases. In preparing the plan with the tangata whaiora they should be encouraged to consider any barriers / potential stumbling blocks and actions that can be taken to lessen the likelihood of these. A priority consideration is the ability of the tāngata whaiora to be able to achieve their goals. The recovery plan is continuously updated to meet the current needs / context of the tāngata whaiora.

Tāngata whaiora will have access to a copy of their recovery plan at all times. The most appropriate format and style of information on the recovery plan for the tāngata whaiora will be made available. Any recovery plan not in a CWS template will need to be uploaded to CWS.

With the consent of the tāngata whaiora, whānau will have access to the components of the recovery plan agreed by the tāngata whaiora.

2.4.6 Recovery plans are communicated in a manner that is understandable to the tāngata whaiora, the staff responsible for implementation of the plan, and with the consent of the tāngata whaiora and their whānau of choice

The following must be considered in the documentation of a recovery plan:

- The health literacy needs of the recipients of the plan. See Health Quality & Safety Commission 'Three steps to meeting health literacy needs. Ngā toru hīkoi e mōhiotia ai te hauora': https://www.hqsc.govt.nz/resources/resource-library/three-steps-to-meeting-health-literacy-needs/. Accessed 7 September 2022
- The age and developmental stage of the tāngata whaiora
- The person/s that the tāngata whaiora has consented to be involved in their recovery planning process
- The use of positive and respectful language. See document on Te Pou site: Real language, real hope https://www.tepou.co.nz/resources/real-language-real-hope. Accessed 7 September 2022

3 Patient information

A tāngata whaiora and whānau booklet will be available on recovery planning.

Posters will be displayed promoting tāngata whaiora and whānau involvement in recovery planning.

4 Audit

4.1 Indicators

National KPI on % valid recovery plans in ICAMHS

KPI measuring inpatient length of stay in adult mental health

Community Mental Health and Addictions services audit indicators:

- There is evidence that the tāngata whaiora has been involved in the recovery planning process in the clinical record (substitute whānau or career where appropriate)
- There are clearly defined goals from a person centred perspective
- The goals are in plain language and free from health jargon
- Early warning signs and stressors / triggers are identified and strategies to mitigate them
- There is evidence of whānau engagement in any part of the plan (e.g. it might be in EWS

Inpatient recovery plan audits are based on the Ngā Paerewa Health and Disability services standard (2021) criteria 3.2.1 – 3.2.7.

4.2 Tools

National KPI is monitored by the Business Analyst and information provided to the Mental Health Clinical Governance Forum monthly.

Community Mental Health and Addictions Services audit on recovery plans

Mental Health and Addictions Service Inpatient Tracer audit tool.

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

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https://www.tepou.co.nz/resources/real-language-real-hope. Accessed 7 September 2022

5.3 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Advance Directives procedure (2181)
- Mental Health and Addictions Integrated Care Pathway policy (1703)
- Mental Health and Addictions Whānau Inclusive Practice guideline (5795)
- Mental Health and Addictions Keyworker procedure (1558)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Mental Health and Addictions Clinical Workstation Recovery Plan template appropriate to the context of the service
- Clinical Records Management policy (0182)
- Informed Consent policy (1969)
- Nursing Assessment, Care Planning, Intervention and Evaluation policy (5285)

5.4 External Standards

- Health Practitioners Competence Assurance Act 2003
- Medical Council of New Zealand Standards
- New Zealand Nursing Council competencies for nurse practitioners
- New Zealand Nursing Council competencies for registered nurses
- New Zealand Nursing Council competencies for enrolled nurses
- New Zealand Nursing Council Guidelines for Cultural Safety, The Treaty of Waitangi and Māori Health in nursing, education and practice
- New Zealand Psychologists Board Competencies for Registered and Clinical Psychologists
- Ngā Paerewa Health and Disability services standards NZS8134: 2021
- Occupational Therapy Board of New Zealand Competencies of Registration and Continuing Practice
- Social Workers Registration Board New Zealand Core Competence Standards

Requests for weekend physical monitoring of service users commencing Clozapine treatment

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Ellyn Gooding
Document Facilitator Title	Charge Nurse Manager
Document Owner Title	Director Clinical Services
Document Owner Name	Rees Tapsell
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
2	Ellyn Gooding	December 2015	Change from Crisis Assessment Team to Crisis Assessment and Home Treatment Team
3	Ellyn Gooding	March 2019	Minor changes to wording and removal of reference to 'ACCIS'.
4	Ellyn Gooding	April 2022	Service user / tāngata whaiora changed to tāngata whaiora Scope and Flow chart updated

Requests for weekend physical monitoring of service users commencing Clozapine treatment

Contents

Requests for weekend physical monitoring of service users commencing Clozapine treatment

1. Overview

1.1 Purpose

- To develop a clear and consistent process.
- To make this process visible and available across all Community Mental Health teams based at 193 London Street, Hamilton.
- To support Keyworkers / sector clinicians with a simple referral process.
- Promote collaboration between services / teams to ensure interventions occur as planned.

1.2 Scope

Applicable to staff working in the sector community mental health teams, the Assertive Community Treatment team and the Crisis Assessment and Home Treatment team in the Mental Health and Addictions Service.

Requests for weekend monitoring from other mental health teams within the immediate Hamilton area are considered on a case by case basis. This includes Hauora Waikato.

1.3 Patient / client group

This procedure relates to tāngata whaiora that require physical monitoring over weekends and during out of hours following the commencement of Clozapine.

1.4 Exceptions / contraindications

This procedure does not apply to tāngata whaiora that do not require weekend physical monitoring following the commencement of Clozapine at the weekend.

1.5 Definitions

- ACT – Assertive Community Treatment team
- CAHT – Crisis Assessment and Home Treatment team

2. Clinical Management

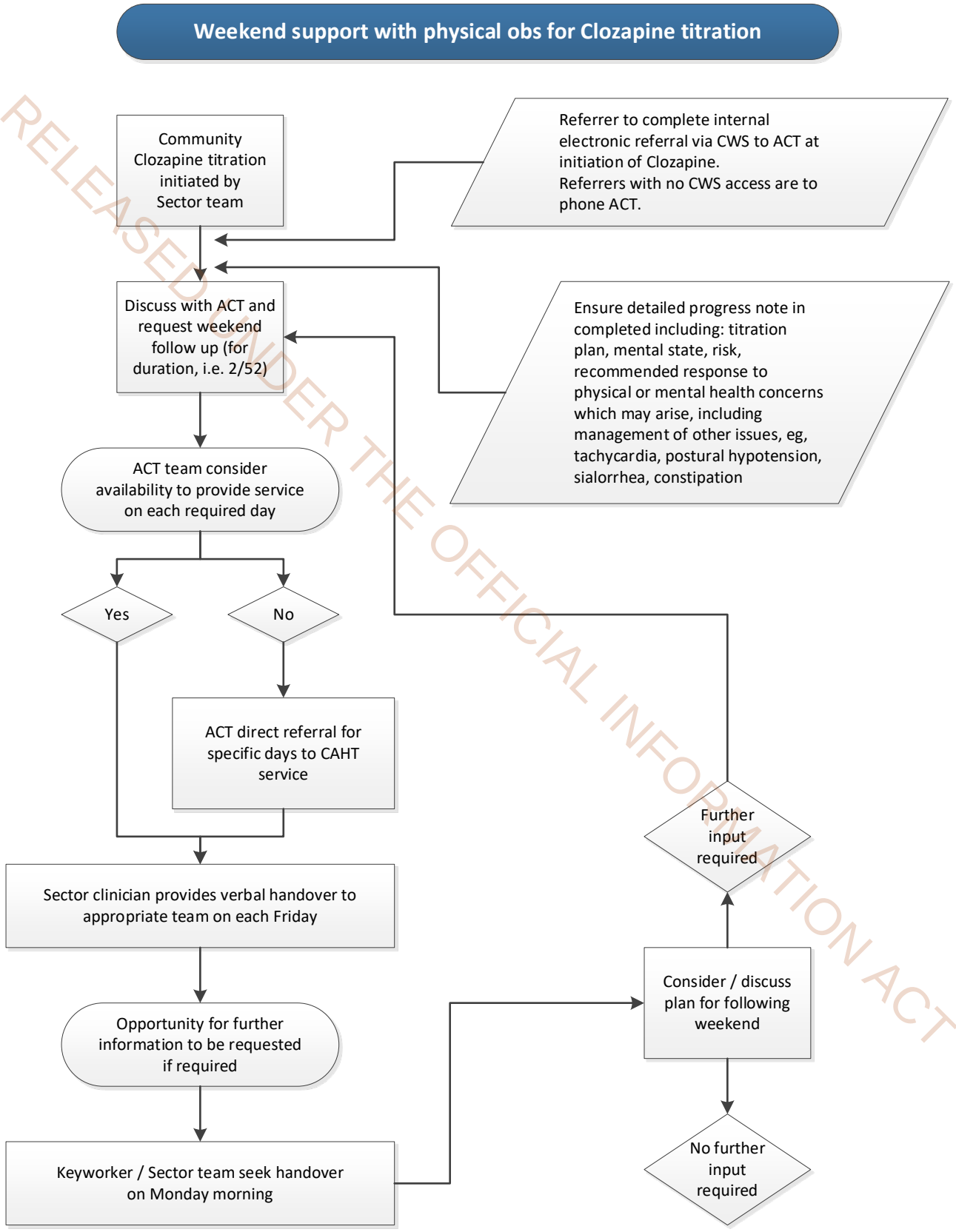
2.1 Competency required

Registered Nurse

2.2 Equipment

R1018MHF – AMHS Internal referral form Community Mental Health Progress note.

2.3 Procedure



2.4 Patient Information

Nil

3. Audit Indicators

3.1 Indicators

Tāngata whaiora 'requiring weekend physical monitoring following the commencement of Clozapine are referred utilising the defined process.

3.2 Tools

An audit of referrals shows that the process for referral for Clozapine monitoring is appropriately followed.

4. Evidence Base

4.1 Associated Documents

- BAO 'Be aware of' – Crisis Assessment and Treatment Service procedure (Ref. 2712)

Safeguarding Assets (property, cash and cash assets)
Mental Health and Addiction Services community sites, Te Whatu Ora – Waikato

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addiction services
Document Facilitator Name	Clindella Stirling
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Director of Clinical Services - MHAS
Target Audience	All community based mental health and addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
01	Cara Thomas	November 2022	First draft – new procedure required

Safeguarding Assets (property, cash and cash assets)
Mental Health and Addiction Services community sites, Te Whatu Ora – Waikato

Contents

Safeguarding Assets (property, cash and cash assets)
Mental Health and Addiction Services community sites, Te Whatu Ora – Waikato

1 Overview

1.1 Purpose

The purpose of this procedure is to outline guiding principles around the management of staff access to Te Whatu Ora Waikato property including but not limited to ensuring the security of credenzas, cupboards, rooms and buildings where assets are located.

1.2 Staff group

This procedure applies to all Te Whatu Ora Waikato staff at community based mental health and addictions sites. This applies to any community base and is not site specific.

1.3 Patient / client group

Not applicable to patient/client group except as intended recipients of cash assets.

1.4 Exceptions / contraindications

Nil exceptions

1.5 Definitions and acronyms

NHI	National Health Index
He Toa Takatini	Current urban base for a number of mental health and addictions teams at 193 London Street.
Property	Items that are owned by Te Whatu Ora – Waikato including electronic devices
Cash and cash assets	Vouchers purchased for the purpose of supporting tangata whaiora • Pak n Save and fuel vouchers • P-cards • Petty cash
Fraud	Fraud is any illegal act characterised by deceit, concealment or violation of trust designed to deceive so as to derive some direct or indirect personal gain,(including via extended family members) benefit or advantage. Examples of fraud may include but are not limited to misappropriation or theft of funds, intellectual property, assets or supplies (including any consumable, pharmaceutical or piece of equipment purchased or owned by Te Whatu Ora Waikato).

2 Clinical management

2.1 Roles and responsibilities

All Staff

All clinical staff are required to understand their role and apply the practices outlined within this procedure in order to optimise security and to mitigate opportunity of theft of property, cash or cash assets.

Managers

Managers are required to make sure their staff are aware of the expectations around property, cash and cash asset management. This includes regular reminders about vigilance of building security including the closing of any open windows and securing of any spaces that need to be locked (credenzas, doors).

Managers are required to approve access to cash assets, and ensure that all staff electronic device purchases are undertaken only using the customer portal, which ensures IS asset management is optimised.

Contractors

Security contractors are required to comply with agreed security plans for each site. This should be reviewed by operations manager and security manager on a six monthly basis, to ensure that mutually agreed security plan remains in place.

2.2 Equipment

All requests for new work devices (phones, laptops and desktops) must be made by team manager through the customer portal so that the asset register can be maintained and current at all times.

Devices such as desktops are situated, and will remain, in the team that obtained them. Any removal of such devices should be an exception (eg: lockdown) and must be recorded as removed, and returned. This should be managed by the team leader, charge nurse manager.

2.3 Procedure

Robust processes and controls should be in place to safe guard assets from misappropriation.

Each MHAS community base/site that stores cash and cash assets must ensure the purchase of a lockbox which is secured to the building. It should not be able to be readily removed. Pincode access required, and the access code is to be known only by key members of staff and not to be shared with others.

Staff and cleaners are to be routinely reminded about need for vigilance associated with building security including closure of external windows.

Cash:
Petty cash must be stored securely at all times in the secure lockbox and must be managed in accordance with organisational procedure/guidelines for petty cash management. Petty cash refunds are to be managed by accounts payable.

Cash assets:
All cash assets (including vouchers) are to be stored securely at all times in the secure lockbox. Issue management process is to be followed, recording serial numbers and reference to specific client issue and staff member requesting. No vouchers are to be issued without Level 6 manager approval. Refer appendix.

Purchasing Cards (P-Cards):
Te Whatu Ora Waikato purchasing cards (where available) must be secured in the secure lockbox at all times, and functionality of card must not include paywave.

All purchases are approved by the card custodian first.

- Before the Purchasing Card (P-card) is used, staff need to read and sign the P-card User Agreement Conditions of Use. Once signed this form is forwarded to Accounts Payable and copied to HRBC Admin who retain a copy on file.
- The member of staff is also given a copy of the Purchasing Card (P Card) policy. They read it and confirm that they are aware of the conditions
- All receipts have a description of what the purchase was for and the staff members name on the receipt, these must be returned with card.
- The P-card and receipts are placed in a cash box which is then placed in a locked drawer.

Custodians must ensure completion of the online process is carried out and forwarded to an approver with all receipts monthly, as outlined in the Purchasing Card (P Card) policy.

All P-card expenditure records are reviewed by Accounts Payable on a Monthly basis

3 Community base security.

External checks are to be conducted with frequency each night.

Security are expected to park outside the building, walk around the outside checking doors and windows are secure, walk through the pool cars parked outside building to check for damages, and to check the onsite garage as part of the nightly patrol rounds.

Any garages or sheds must be secured overnight and on weekends.

Any incident or potential incident of concern must be escalated immediately to the appropriate Level 5 Operations Manager. If that operations manager is not available, it must be escalated immediately to Level 4 Manager.

4 Audit

4.1 Indicators

- In accordance with P-card Policy (0440) all P-card expenditure records are reviewed by Accounts Payable on a Monthly basis
- Pak n Save voucher issue management record is to be returned to accounts payable monthly for reconciliation.
- MTA fuel voucher issue management record is to be audited by lead administrator six monthly.
- In accordance with petty cash guidelines (refer Appendix A) records are reviewed by Accounts payable on a monthly basis.

4.2 Tools

- P card user agreement – conditions of use form
- Template for petrol voucher issue and usage
- Template for petty cash expenditure reimbursement
- Template for Pak n Save Voucher issue

5 Summary of Evidence, Review and Recommendations

Findings/recommendations following Internal audit – HealthShare, March 2022

6 Associated Te Whatu Ora Waikato Documents

- Assets and Equipment policy (Ref. 1839)
- Code of Conduct policy (Ref. 5674)
- Fraud policy (Ref. 3274)
- Information Security policy (Ref. 3153)
- Information Security – Asset Management guideline (Ref. 5843)
- Mobile Communication Devices Management policy (Ref. 1853)
- Purchasing Card (P Card) policy (Ref. 0440)
- Security policy (Ref. 0120)

7 Legislative requirements

- Relevant to this procedure – includes but is not limited to;
- Crimes Act 1961
- Trespass Act 1990

Appendix A – Petty cash guidelines

WAIKATO DISTRICT HEALTH BOARD

PETTY CASH GUIDELINES

Petty Cash accounts should be used to reimburse expenses incurred by staff for small items up to the value of $50.00

These items include:

Groceries
One-off Stationery Supplies
Repairs to Equipment
Pharmacy Items

Fruit and Vegetables
One-off Newspaper Purchases
Small Maintenance/Repairs to Buildings
Koha

This list is not meant to exclude any items but to provide examples. If you are unsure please contact your Accountant or the Accounts Payable Team Leader for clarification.

Petty Cash is **not** to be used for payment of goods already received or for payment of any items which can be purchased by account including:

Capital Purchases
Electricity/Gas
Telephone
Rates
Contract Cleaning
Course Conference Items
Regular Recurring Costs Vouchers - all vouchers which are like cash Petrol - MTA vouchers are available from the Cashiers Office with a completed paper requisition form or staff seeking reimbursement should complete a staff expense claim form.

This list is not meant to exclude any items but to provide examples within the guidelines. Items that are subject to entertainment tax or fringe benefit tax may not be purchased using this account, e.g. lawn mowing, car washing.

Reimbursement requests should be submitted weekly.

To claim reimbursements complete a Petty Cash Expenditure Reimbursement Form.

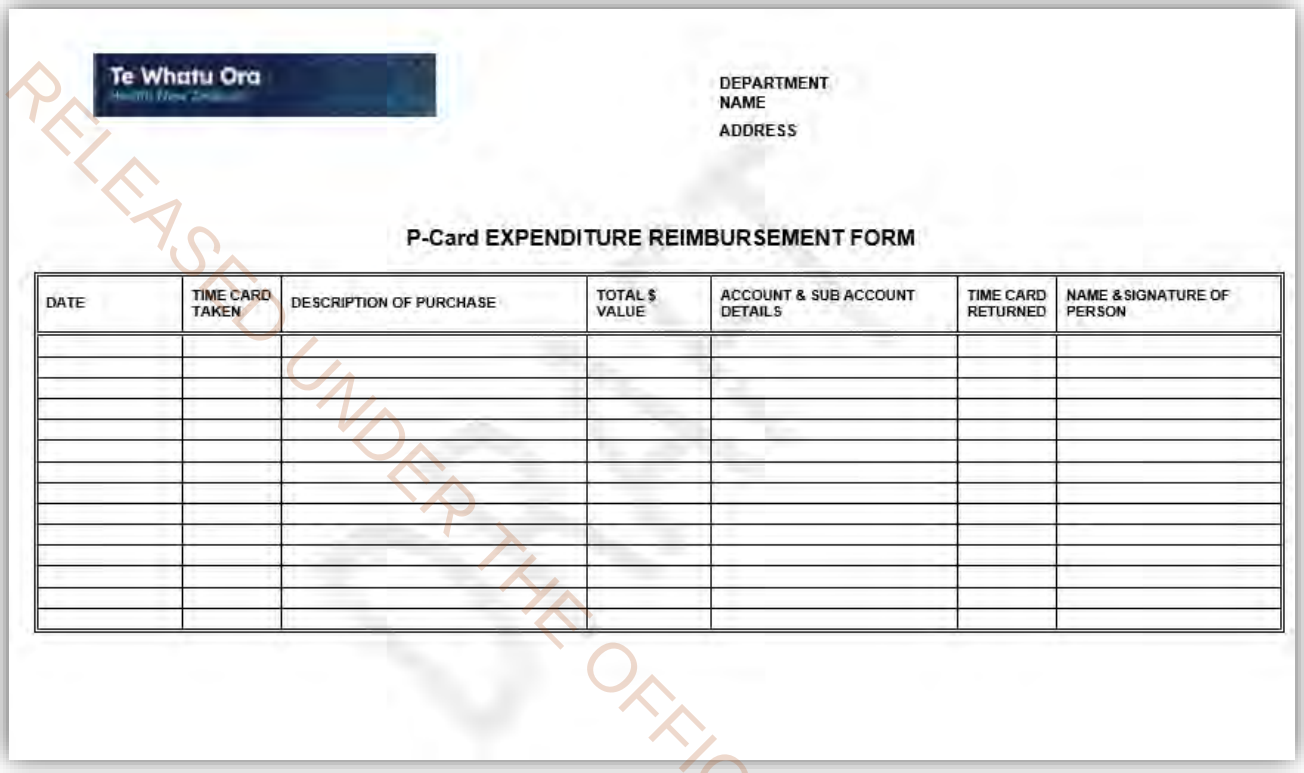
Complete the form with the date expense incurred, description of items purchased, amount reimbursed (amount paid out not the amount on the receipt e.g. receipt = $25.42 paid out = $25.40), Indicate if GST is to be claimed, advise the appropriate Responsibility Centre (RC) and General Ledger cost code (GIL). Signature of person receiving the reimbursement. Attach an adding strip along with all tax invoices / receipts making up your request for reimbursement. Your signature as the person who compiled the form and the appropriate delegated authority must authorise.

Email a copy of your completed form to Accounts.Payable@waikatodhb.health.nz and advise when you wish to collect.

Bring your original claim form to Accounts Payable and be given cash in exchange.

Non-compliance with these guidelines may result in your float being withdrawn.

Appendix B – Template for use – P-Card Expenditure Reimbursement Form



Te Whatu Ora

DEPARTMENT NAME

ADDRESS

P-Card EXPENDITURE REIMBURSEMENT FORM

DATE	TIME CARD TAKEN	DESCRIPTION OF PURCHASE	TOTAL $ VALUE	ACCOUNT & SUB ACCOUNT DETAILS	TIME CARD RETURNED	NAME & SIGNATURE OF PERSON

Appendix C – Template P-Card User Agreement Conditions of Use

Te Whatu Ora
Health New Zealand

P-CARD USER AGREEMENT
CONDITIONS OF USE

USER DETAILS

Full Name: _____

Department/Ward: _____

Your participation in the P-Card Program carries the responsibility of complying with the general and special Conditions of Use detailed below. This card should at all times be used with good judgement. Your signature on this agreement signifies your acceptance of the Conditions of Use.

CARD USER CERTIFICATION

I, _____, have read and agree to comply with the Conditions of Use for the P-Card. I agree Te Whatu Ora Waikato District will recover from me any inappropriate unapproved expenditure that I have transacted using this card.

Signature: _____ Date ___ / ___ / _____

AUTHORISED CARD CUSTODIAN CERTIFICATION

I, _____, as an Authorised Card Custodian of Te Whatu Ora Waikato District's Purchasing Card Program have explained the conditions of use to the Client as detailed below and agree to their use of the Te Whatu Ora Waikato District's P-Card.

Card Custodian Signature: _____ Date: ___ / ___ / _____

CONDITIONS OF USE

1. You must retain receipts from all your purchases and give these to the Card Custodian when returning the P-Card.
2. You are responsible for securing the card and PIN from loss and theft when it is in your possession. However, if this occurs you must immediately notify your P-Card Custodian.
3. You may not use the card to obtain cash from ATMs, EFTPOS terminals and bank branches. Specific suppliers have been restricted from use and will not accept this card.
4. Improper use of the Purchasing Card will be considered as misappropriation of the Te Whatu Ora Waikato District's funds and fraudulent use may result in the instigation of legal proceedings.

Appendix D – Monitoring MTA fuel voucher issue and use, including template form

Audit action: six monthly – April and October. Audit records at each site for consistent record keeping and storage to safeguard. Results to be tabled in a report to Quality forum in May and November.

Template

MTA (Fuel) vouchers

Te Whatu Ora

Voucher Numbers:

PURCHASE ORDER			PURCHASE DETAILS				
Voucher No:	Date	Client Name	NHI	Staff Member	Receipt	Staff Signature	TOTAL $ VALUE
							10.00
							10.00
							10.00
							10.00
							10.00
							10.00
							10.00
							10.00
							10.00
							100.00

Signed:

Name

Date

Appendix E – Record of Issue: Pak n Save Vouchers

Audit action: six monthly – April and October. Audit records at each site for consistent record keeping and storage to safeguard. Results to be tabled in a report to Quality forum in May and November.

Financial oversight by broader organisation in reconciliation by accounts payable.

Template:

PAK N SAVE VOUCHERS

Voucher Numbers:

Te Whatu Ora

PURCHASE ORDER			PURCHASE DETAILS				
Voucher No:	Date	Client Name	NHI	Staff Member	Receipt	Staff Signature	TOTAL $ VALUE

Signed:

Name

Date

Appendix F – Record of petty cash expenditure reimbursement form

Audit action: six monthly – April and October. Audit records at each site for consistent record keeping and storage to safeguard. Results to be tabled in a report to Quality forum in May and November.

Financial oversight by broader organisation on a monthly basis in reconciliation by accounts payable.

Template

CBD Waiora
Building
Alexandra Street

Te Whatu Ora

PETTYCASH EXPENDITURE REIMBURSEMENT FORM

DATE	DESCRIPTION OF PURCHASE	TOTAL $ VALUE	GST	RESPONSIBILITY CENTRE & GENERAL LEDGER COST CODES	SIGNATURE OF PERSON COLLECTING REIMBURSEMENT

TOTAL REIMBURSEMENT REQUIRED

CASH IN HAND

TOTAL FLOAT 150.00

COMPILED BY:

CHECKED BY:

DATE

Searching of mental health tāngata whaiora in relation to illicit substances / dangerous articles

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions staff
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Te Whatu Ora Health New Zealand assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
06	Rees Tapsell	December 2015	Changes to new DHB controlled document format with addition of roles and responsibilities, and inclusion of statement about maintaining the dignity of the service users when articles of clothing are removed.
07	Kylie Balzer	July 2019	Change from policy format to procedure format
08	Kylie Balzer	October 2023	Change to Te Whatu Ora Waikato procedure template Change in terminology from service user / tāngata whaiora to tāngata whaiora; from the Henry Rongomau Bennett centre to the inpatient mental health service Added in associated Te Whatu Ora Waikato document: Alcohol, Illicit Substances and Drug Abuse – Patients and Visitors Policy (1831)

Searching of mental health tāngata whaiora in relation to illicit substances / dangerous articles

Contents

Searching of mental health tāngata whaiora in relation to illicit substances / dangerous articles

1 Overview

1.1 Purpose

This procedure sets out the organisations standard for searching Mental Health tāngata whaiora in inpatient mental health wards in relation to illicit substances and / or dangerous articles.

All mental health and addictions staff are required to follow the requirements of the Te Whatu Ora Alcohol, Illicit Substances and Drug Abuse – Patients and Visitors policy (1831).

1.2 Staff group

This document is applicable to Te Whatu Ora Waikato mental health inpatient units ONLY.

1.3 Patient / client group

Mental health tāngata whaiora.

1.4 Exceptions / contraindications

Nil exclusions.

1.5 Definitions and acronyms

Illicit substances	Any of these substances or drugs listed as a controlled drug in the Misuse of Drugs Act 1975
Imminent danger	An obvious and impending "likely to occur" risk based on history and current presentation, that is assessed to be of no less than serious physical or psychological harm to themselves or others.
Informed consent	The right to make an informed choice about whether or not to accept treatment. A tāngata whaiora gives informed consent after they have been adequately informed about the risks and benefits involved in any treatment, compared to alternative treatments, or no treatment at all. Practitioners must ensure that tāngata whaiora are given sufficient information to make their own decisions about their treatment. Refer also to consent detailed in the Code of Health and Disability Services Consumers' Rights (The Code): Right 5 Effective Communication Right 6 The right to be fully informed
Mental health clinician	Means a person who holds a professional qualification relevant to the assessment, treatment, and care of patients and proposed patients with mental disorder (Sec 2 MHA, 1992)
Personal search	When staff are required to physically search a tāngata whaiora which may involve, against their will, the removal of personal clothing by use of force. For *illicit substances* police are the only authorised agency to carry this out, for *articles of potential harm* refer to 2.4.5

Tāngata whaiora	Refers specifically to anyone who is a recipient of services within the inpatient mental health service, for instance, subject to Compulsory Assessment & Treatment under the Mental Health Act 1992, or the Criminal Justice Act 1985 sections 115, 118, or 121, or informal.
Senior nurse	Refers to the nurse in charge of the unit, or the after-hours duty coordinator for the mental health inpatient service

2 Clinical management

2.1 Roles and responsibilities

All Staff

All staff have a role in supporting the maintenance of a safe environment for tāngata whaiora, staff and the public.

Clinicians

Clinicians must make informed decisions based on assessment and respect the rights and dignity of tāngata whaiora. Clinicians must seek support, advice and assistance as required; provide clinical care and oversight and meet the requirements of this procedure based on the context of the situation.

Managers

Managers need to ensure this procedure is included in the service orientation programmes and ongoing education. They must monitor incidents and complaints to ensure this procedure is being complied with, and ensure any necessary improvements are actioned.

2.2 Competency required

Registered nurses and senior mental health clinicians must be made aware of this procedure as part of their orientation to the service.

2.3 Equipment

- Clinical record
- DATIX incident reporting system

2.4 Procedure

2.4.1 Authority to Search

Mental Health staff have no legal authority to enforce personal searches. However, clinical assessment and judgement relating to safety may indicate a personal search is considered necessary.

These situations include circumstances:

- Where there is a reasonable cause to suspect a tāngata whaiora may have illicit substances and
- Where there is perceived *imminent danger* due to a tāngata whaiora concealing articles of potential harm, e.g. weapons, prescription drugs.

2.4.2 Guiding Principles

- All tāngata whaiora are to be informed of the Mental Health service procedure on illicit drugs and dangerous articles as part of the admission procedure
- All mental health inpatient staff are informed of the Mental Health service procedure on illicit drugs and dangerous articles as part of orientation and ongoing mental health staff education
- Informed consent is considered the most desirable circumstance under which to complete a search
- Where practical, tāngata whaiora should be encouraged to have a support person present during the search process
- The dignity and wellbeing of the tāngata whaiora should be protected during the course of any personal or physical search. This means gender and culturally appropriate staff should be utilised wherever possible.
- The decision to conduct a search should be considered carefully and advisedly and involve consultation with senior members of the health team and service
- It is an offence to restrain without legal excuse, health professionals must be able to justify the use of restraint
- The potential for dangerousness is very real in search situations especially if weapons are involved. If staff need to search a tāngata whaiora, particularly in circumstances against their will, they must do so safely; utilising staff resource, safe environment, psycho-social de-escalation and / or restraint techniques as necessary and appropriate.

2.4.3 Procedure or Process – General

A clinical judgement based on assessment of the situation will determine if a personal search is to be undertaken.

An attempt must first be made to gain consent from the tāngata whaiora first. If informed consent is not gained please refer to 2.4.4. and 2.4.5.

If a search is to proceed it should involve interventions to the minimum degree of invasiveness required to carry out a search safely, i.e.:

- Search takes place in a safe environment that also ensures privacy, e.g. interview room
- Ask the tāngata whaiora to present any articles or substances they may have on their person

- As necessary, ask the tāngata whaiora to empty their pockets
- As necessary, ask the tāngata whaiora to remove articles of their clothing for checking
- If there are continued concerns that the tāngata whaiora has concealed articles / illicit substances within or on their person then they should be maintained in a safe environment under high levels of observation until further consultation occurs with the clinical team
- A registered nurse and gender appropriate staff must be present taking into account cultural / personal dignity / clinical issues for that person

In all situations involving a search, details of consent, process used and outcomes achieved are fully documented in the individual's clinical file and a DATIX incident notification completed.

2.4.4 Procedure or Process – Illicit substances

Tāngata whaiora under a compulsory legal order i.e. Mental Health (Compulsory Assessment & Treatment) Act 1992, or the Criminal Procedures (Mentally Impaired Persons) Act 2003 who are suspected of illicit drug / substance possession, (i.e., no imminent danger), should be placed under an appropriate level of observation and if necessary isolated into a safe environment away from others to ensure illicit drugs / substances are not taken, passed on or hidden.

In the case of informed consent not gained and a personal (hands on) search for illicit substances is still deemed necessary, police assistance *is required in* relation to their powers under section 18(2)/(3) of the Misuse of Drugs Act, 1975, as they are the only authority allowed to enact a search in these circumstances.

As necessary, tāngata whaiora may be asked to remove articles of their clothing for checking, however, should this be required, the tāngata whaiora dignity should be respected at all times, (where possible avoiding full exposure or prolonged exposure).

A decision to call police must involve two *mental health clinicians* to support this action, i.e. involves the senior nurse on duty and the responsible clinician (or delegate) and a DATIX incident notification completed.

At the time of the police search, the senior mental health clinician / registered nurse present is:

- Responsible to provide clinical care and oversight
- Ensures that gender appropriate staff are present

In situations outside of police searches where staff find a usable amount of illicit drugs or substances a senior nurse on duty will notify the police. It is expected that prior to police contact, consultation will occur with the medical officer or registrar on duty.

When drugs are found, these will be labelled and stored in the nearest locked drug cupboard until the police arrive.

When illicit drugs are to be disposed of, this must be done in the presence of two registered nurses as witnesses.

2.4.5 Procedure or Process – Articles of potential harm

"Everyone is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or of the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which s/he believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence." (Section 41 of the Crimes Act 1961)

In urgent situations where there is reasonable cause to believe that:

- a tāngata whaiora has concealed a dangerous article
- and *imminent danger* is thought likely either to the tāngata whaiora or others
- Informed consent is not obtained

A forcible search carried out in line with this policy by mental health staff acting in good faith using reasonable caution and force can be justified.

A decision involving **two mental health clinicians** must be made that supports this action, e.g. involves the senior nurse on duty and the responsible clinician (or delegate). These discussions are recorded in the individual clinical record.

Also refer to "Matters of justification or excuse" sec 122 Mental Health (Compulsory Assessment and Treatment) Act 1992.

2.4.6 Property

If informed consent is not obtained for a property search, then staff will consider whether or not the property should be stored away in a separate area.

3 Patient information

Mental Health and Addictions service information for tāngata whaiora

4 Audit

4.1 Indicators

Audits of incident reports resulting from staff or police searches indicate that personal searches are carried out safely, legally, in accordance with this procedure and without injury to staff or tāngata whaiora.

Complaints received from tāngata whaiora / whānau / advocate / district inspector in relation to searches are attended to and on investigation staff processes are found to be justified and appropriate.

4.2 Tools

Incident system and complaints processes

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Alcohol, Illicit Substances and Drug Abuse – Patients and Visitors policy (1831)
- Clinical Records Management policy (0182)
- Incident Management policy (0104)
- Restraint policy (2162)
- Mental Health and Addictions Puawai Internal Security procedure (2687)

5.2 External Standards

Ngā Paerewa Health and Disability services Standards NZS8134:2021

Legislation:

- Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Health and Disability Commissioner Act 1994
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations1996
- Crimes Act 1961
- Criminal Justice Act 1985
- Criminal Procedures (Mentally Impaired Persons) Act 2003
- Human Rights Act 1993
- Intellectual Disability Compulsory Care and Rehabilitation Act 2003
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment Act 2021
- Misuse of Drugs Act 1975
- Privacy Act 2020

Seeking advice and or assessment from Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) at the time of initial mental health crisis assessment

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Clinical staff in the mental health and addictions service
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes

Seeking advice and or assessment from Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) at the time of initial mental health crisis assessment

Contents

Seeking advice and or assessment from Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) at the time of initial mental health crisis assessment

1 Overview

1.1 Purpose

This procedure outlines when to escalate an initial tāngata whaiora crisis assessment to a mental health Resident Medical Officer (RMO) or Senior Medical Officer (SMO).

1.2 Staff group

All clinical staff in the mental health and addictions service who complete initial crisis assessments.

1.3 Patient / client group

All tāngata whaiora receiving an initial crisis assessment.

1.4 Exceptions / contraindications

This procedure does not apply in the following circumstances:

- Mental health assessments that are not crisis related.
- When there is a pre-existing management plan in place that applies to the circumstances of assessment for an individual tāngata whaiora.

1.5 Definitions and acronyms

Initial Crisis assessment	Crisis assessment is the process used with an individual to collect information related to the individual's presenting issue, history and needs and strengths in order to determine appropriate services required during an acute crisis episode.

2 Clinical management

2.1 Roles and responsibilities

Clinicians
All clinicians who undertake initial crisis assessments must know about, understand, and complete the requirements of this procedure

Managers (CNM's, ACNMs, Team Leaders)
Managers of areas where initial crisis assessments are completed must ensure that monitoring of this procedure occurs, and any improvements required are acted on.

2.2 Competency required

Registered mental health clinician (SMO, RMO, Nurse Practitioner, Registered Nurse, Occupational Therapist, Social Worker)

2.3 Equipment

- Assessment – Mental Health and Addictions Service clinical workstation document
- Communication devices

2.4 Procedure

2.4.1 Clinical staff must contact the responsible RMO/SMO regarding tāngata whaiora receiving an initial crisis assessment in the following situations and RMOs and SMO's must ensure they are available to respond

- Situations where the tāngata whaiora requires medical treatment in an emergency department following an actual self-harm event
- Where tāngata whaiora symptoms and / or behaviour are suggestive of:
  - Psychosis
  - Moderate to severe depression
  - Agitated depression
- Risk to self is assessed as moderate to severe based on one or more of the following factors:

  Planning and Means

  - Where there is the presence of research and planning prior to the self-harm event. by tāngata whaiora
  - There is preparation by the tāngata whaiora (gathering what is required to action self-harm).

  Intent

  - There is a level of intention to self-harm (the expectation to end life as opposed to a help-seeking action).
  - The presence of ambivalence / disappointment of unsuccessful self-harm.

  Lethality

  - Where there is a presence of significant lethality (self-strangulation by hanging, carbon monoxide by gassing, significant overdose of medicines or substances).

  Circumstance

  - When the trigger for the suicide attempt / ideation remains unchanged and there is no apparent mitigation.
  - When the tāngata whaiora is guarded or is disengaged from the assessment
  - When the tāngata whaiora remain agitated
- Risk to others is assessed as moderate to severe, which is informed by:
  - Actual harm to others

- Recent actual harm to others
- Imminent risk of harm to others
- Homicidal ideation

- Minors under 18 years of age
- Any situation when the clinician is uncertain of the risk, uncertain of the management plan going forward, have sought a peer opinion and there is a disagreement, and otherwise have intuitive concerns or feel uncomfortable about a decision.

2.4.2 2.4.2 RMOs must contact the responsible SMO regarding tāngata whaiora they see or admit

As per the requirements of the Te Whatu Ora Waikato Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs policy (2561).

3 Audit

3.1 Indicators

- Audits of clinical records demonstrate that a clinician has had a discussion with a RMO/SMO as part of the initial crisis assessment as per the requirements of this procedure.

3.2 Tools

- Initial crisis assessment clinical document specific to this procedure

4 Evidence base

4.1 Summary of Evidence, Review and Recommendations

- Input from Crisis Assessment and Home Treatment (CAHT) clinicians, and mental health and addictions medical staff and leadership.
- Risk information from the New Zealand Mental Health Foundation.
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP): When patients should be seen by a psychiatrist

4.2 Bibliography / References

- The Royal Australian and New Zealand College of Psychiatrists (RANZCP): When patients should be seen by a psychiatrist

4.3 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Working with Risk: Assessment and intervention to tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Admission, Discharge and Transfer policy (1848)
- Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs policy (2561)

4.4 External Standards

- NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard

Sensory Modulation

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kim Sharp
Document Facilitator Title	Clinical Lead, Occupational Therapy
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions clinical staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
02		November 2015	This procedure considers the use of sensory modulation as an intervention across MH&AS and replaces the use of the sensory room in inpatient areas
03	Joanne Parker	January 2019	Inclusion of the use of sensory modulation facilities in other organisations Audit indicators updated
04	Kim Sharp	February 2023	Change to current Te Whatu Ora Waikato Quality and Patient Safety Procedure template Change of wording for sensory rooms to reflect multi use spaces Removed Level 2 training as a requirement for OTs. Change from Sterigel to antibacterial hand rub, and from Tuffie wipes to V-wipes. Change to patient information section Increased focus on Māori health needs Inclusion of the environment in addition to equipment

Sensory Modulation

Contents

Sensory Modulation

1 Overview

1.1 Purpose

Sensory modulation is a clinical tool for use in mental health and other clinical areas. From Te Pou (website 2023) " Sensory modulation involves supporting and guiding people in using senses such as sight, sounds, smells, touch, taste, movement to self-manage and change emotional state." The origins of the therapy come from the field of occupational therapy but can be used across all disciplines.

This procedure aims to

- Guide all staff in the use of sensory modulation, in the Mental Health and Addiction Service (MH&AS), as a therapeutic clinical intervention for use within inpatient units and in community setting including homes of tāngata whaiora
- Provide guidance for the use of the sensory modulation room, the activities and equipment and to ensure a safe environment
- Ensure safety of tāngata whaiora and staff in all aspects of sensory modulation across the Mental Health and Addictions Service
- Ensure staff are able to be offered sensory modulation as one of the choices available to support them to achieve their wellbeing goals and are supported by staff with the necessary skills and knowledge to safely do so
- Ensure there is a partnership approach in sensory modulation to promote equitable health care outcomes for Māori.

1.2 Staff group

Clinical staff in the Mental Health and Addictions Service.

1.3 Patient / client group

Tāngata whaiora across the Mental Health and Addictions Service.

1.4 Exceptions / contraindications

Staff working in the community setting need to be mindful of tāngata whaiora own choice in their homes.

1.5 Definitions and acronyms

Occupational life roles	Occupational life roles are the roles that we do in everyday life that define who we are
Sensory Equipment	The use of specific equipment which caters to all of the senses. This enables the development of personal knowledge about sensory processing, an understanding of sensory preferences and individuals' response to environments, situations, activities and people.
Sensory Modulation	The capacity to regulate and organise the degree, intensity, and nature of responses to sensory input in a graded and adaptive manner. This

	allows the individual to achieve and maintain an optimal range of performance and to adapt to challenges in everyday life (Miller & Lane, 2000)
Sensory profile	An assessment of a person's responses to sensory stimuli in everyday life
Sensory Room	A therapeutic environment specifically designed to promote self-organisation and positive change. Sensory modulation rooms can be used for de-escalation and for identifying new skills and preferences that can be transferred to other environments
Sensory Toolkit	A sensory toolkit consists of a group of sensory items gathered together appropriate to an individual to use for calming or stimulating their sensory system

2 Clinical management

2.1 Roles and responsibilities

Registered Clinical Staff

- Attend training in sensory modulation prior to using the sensory modulation room and/or equipment
- Be orientated to the use of the sensory modulation resources (including weighted blankets and its specialised space i.e. "Sensory Room"
- Orientates staff on use of sensory modulation modalities and use of the sensory modulation room
- Ensure all sensory modulation documentation i.e. booking diary, equipment monitoring log and tāngata whaiora visitor book is completed. Individual health record documentation, including goals and outcomes is maintained
- Responsible for ensuring personal safety is maintained through the use of current and effective clinical assessment, use of personal duress alarms, and ensuring visual access is available at all times when sensory equipment / tools are being used
- Adhere to cleaning and hygiene guidelines as per Infection Prevention and Control Procedure for Reprocessing of Healthcare equipment
- Following use of the sensory tools, all items must be cleaned and disinfected and returned to respective locations. Items are not to be removed from sensory rooms or kits unless specifically discussed with the Occupational Therapist
- Where a sensory modulation session is delegated to an approved non registered person, a risk assessment must be made, and they must ensure the delegated person knows when and from whom to seek assistance, and ensure the session outcome is documented in the progress note in CWS. The decision to delegate the supervisory role must be clinically driven at all times, and be cognisant of the most appropriate person for the individual tāngata whaiora.

Occupational Therapists

Provide specialist skills and input in sensory modulation to provide:

- Specialty sensory assessments
- Specialty interventions
- Specialty guidance / leadership on sensory modulation

Charge Nurse Manager or Team Leader

- Identify and support staff to attend sensory modulation training and to maintain knowledge and skills
- Support the ongoing provision of sensory modulation interventions through promotion of its therapeutic benefit and contributing to a confident attitude amongst staff
- Support the ability for tāngata whaiora to have the choice of using sensory modulation to support their recovery
- Actively promote the therapeutic benefits of sensory modulation as one approach to support tāngata whaiora to recognise and reduce their level of distress
- Ensures the budget recognises the need to maintain and purchase therapeutic resources, as recommended by clinical staff who have specialist training in sensory modulation
- Will ensure sensory modulation equipment is maintained and replaced as required
- Drives, supports and maintains use and safety of the sensory room and sensory equipment
- Has overall responsibility for the maintenance, cleaning and purchase of appropriate equipment.

Multidisciplinary team (MDT)

- Discuss and agree the use and anticipated therapeutic effects of sensory modulation for use in a person's individual treatment plan.
- Seek specialised occupational therapy support as required.

Non Registered staff member (Mental Health Assistant, Occupational Therapy Assistant, Activities Facilitator, Kaitakawaenga)

- Must be approved by Charge Nurse Manager, Associate Charge Nurse Manager or delegate, to undertake a sensory modulation supervision role
- They must have sufficient skills and experience to safely undertake the role, know who to go to for help and be able to report back to the delegating clinician observations and outcomes of the session.

Medical Officers / Nurse Practitioner

- Complete a physical health assessment. For sensory modulation purposes this is important to confirm physical health, safe prescribing of essential oils and infection status.

2.2 Competency required

All staff using sensory modulation have completed sensory modulation training.

2.3 Equipment and Environment

Inpatient Environment

- Consideration of the whole inpatient environment sensory impact for tāngata whaiora must be a continuous process by all staff.
- Sensory modulation equipment that caters for all the senses, is to be stored safely within the sensory rooms and/or kits. The equipment is easily accessible for inpatient staff, as per specific guidelines
- Equipment must meet the Te Whatu Ora Waikato standards for Infection Prevention and Control, purchase of equipment and electrical safety testing. All equipment purchased must be a suitable quality and standard to be functional for the purpose intended.

Community Environment

- Sensory modulation equipment available for staff to use when supporting tāngata whaiora is to be safely stored and easily accessible for community staff

2.4 Procedure

2.4.1 Assessment Phase

Sensory modulation as a therapeutic intervention is identified by the health professional and tāngata whaiora to support emotional regulation and wellness following the comprehensive assessment and/or occupational therapy initial assessment.

Sensory modulation as an intervention is discussed and agreed by the multidisciplinary team prior to further assessment.

A suite of assessments need to be considered for sensory modulation

- Appropriately trained clinical staff with specialist competencies will conduct the sensory modulation assessments
- A physical health assessment is undertaken as soon as possible following an inpatient admission by medical staff or nurse practitioner. Where sensory modulation is agreed by the multidisciplinary team the medical staff will confirm physical health in relation to using essential oils and infection status
- Assessment of Sensory Precautions is essential including: Allergies, Trauma History, Seizure History, Environmental effects – lighting, background noise etc., Respiratory /

Cardiac Precautions, Pregnancy, Migraine triggers, Medication changes and side effects

- In conjunction with the sensory modulation assessments staff will conduct appropriate risk assessment and mental state examination as per standardised processes
- Consider cultural needs in assessment for sensory modulation e.g. Māori healing, taonga, connection with whenua and wai.

Documentation of the assessment process will be completed and uploaded in electronic clinical records including: triggers, early warning signs and identified sensory preferences.

2.4.2 Set Goals and Plan Intervention Phase

1. Recovery goals are negotiated and mutually agreed upon between the clinician and the tāngata whaiora (and others, as appropriate).
2. An intervention plan with clear actions is developed. Goals and intervention plans reflect sensory preferences and functionality of sensory modulation specific to the tāngata whaiora needs and context.
3. Assessment, goals and intervention plan will be presented and discussed with the tāngata whaiora, whānau, keyworker and their multidisciplinary team across MH&AS.
4. Recovery goals, identified through the assessment process will be documented into electronic clinical records, specifically in the recovery plan as sensory modulation tools and strategies.

2.4.3 Intervention Phase

Implementation of the sensory modulation plan. The staff continually adapt and grade occupations and specific interventions to enable goal achievement.

Use of Sensory Room – “The sensory modulation room offers a nurturing, person centred, sensory supportive environment and interdisciplinary treatment space. It is used to facilitate empowerment, self-organisation, relaxation, sensory awareness, communication, reality orientation, activity tolerance, uplifting activities, and general awareness of self, peers and the environment.” Champagne (2011, p.241). See Appendix A – Guidelines for Use of Sensory Rooms

When using a sensory room within the community e.g. Life unlimited – sensory room

- Adhere to the organisation procedures and protocols for use of their room including health and safety and infection control
- Complete the specific training requirements prior to using the sensory room

Use of Weighted Blankets – The weighted blanket is a therapeutic modality used to “facilitate self-organisation, reality orientation, sensory awareness, activity tolerance and general awareness of one’s self in the environment” Champagne (2011, p.243). The weighted blanket is never to be used as a restraint. The term “weighted blanket” is used to cover all weighted modalities (including weighted animals). See Appendix B – Guidelines for Use of Weighted Blankets.

Use of Sensory Equipment – Sensory modulation equipment caters for all the senses – smell, sight, touch, taste, hearing, proprioception and vestibular. Availability and use of a wide range of equipment allows the tāngata whaiora to achieve their goals in sensory modulation. The development of sensory modulation will facilitate recovery and integration of sensory modulation into occupational life roles. See Appendix D – Guidelines for safe use of essential oils for aroma based sensory modulation.

All staff are responsible for documenting sensory modulation interventions used and outcomes in clinical notes, including: behaviour, mental state, time spent in the sensory room, sensory modalities used and any adverse events reported. Cultural and sensory interventions are to be incorporated into the recovery plan.

2.4.4 Evaluation Phase

The purpose of evaluation in the sensory modulation process is to ascertain to what extent the tāngata whaiora goals have been achieved and to re-evaluate, set new goals with action plans or discontinue intervention.

Tāngata whaiora using sensory modulation are encouraged to provide feedback which is documented in their clinical record.

2.4.5 Transfer of Care

Tāngata whaiora will have a collaborative plan developed to assist in integrating sensory modulation techniques and strategies into their daily lives. This may include but not limited to early intervention strategies such as advance directives, crisis plans Wellness Recovery Action Plan (WRAP), de-escalation and calming techniques.

Tāngata whaiora will identify valued activities, equipment and resources to support personal sensory modulation to enable recovery and develop a personalised sensory kit. This may include sensory preferences and activities in daily life to achieve a state of emotional regulation through engagement of the senses.

Clinicians who use sensory modulation will provide clear rationale supporting the sensory modulation tools and strategies to colleagues in their multidisciplinary teams and shared care multidisciplinary teams.

Tāngata whaiora with staff will communicate sensory modulation as part of their transfer of care from inpatient to community and community to inpatient environments.

Clinicians will facilitate, through effective clinical reasoning, the purchase of individualised sensory modulation equipment to meet specific tāngata whaiora needs.

3 Patient information

- Verbal explanations are provided to tāngata whaiora on sensory modulation.
- Handouts on sensory modulation resources are provided as required to tāngata whaiora / whānau.

4 Audit

4.1 Indicators

1. Sensory modulation assessment and interventions are documented within CWS for tāngata whaiora referred for sensory modulation
2. All staff using sensory modulation have completed training in sensory modulation.

4.2 Tools

1. Clinical Audit of sensory modulation within tāngata whaiora documentation
2. Monitoring of sensory modulation education completed.

5 Evidence base

5.1 Bibliography / References

- Brown, C. Stoffel, V.C. (2011) Occupational Therapy in Mental Health: A vision for Participation. F.A. Davies Company, Philadelphia
- Champagne, T. (2011) Sensory Modulation & Environment: Essential Elements of Occupation, third edition revised. Pearson Australia Group Pty Ltd.

5.2 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Integrated Care Pathway policy (1703)
- Te Whatu Ora Waikato Infection Prevention and Control procedures via Lippincott Procedures
- Specific assessment tools for sensory modulation
- Te Whatu Ora Waikato Medicines Management policy (0138)
- Te Whatu Ora Waikato Clinical Records Management policy (0182)

5.3 External Standards

- Ngā Paerewa Health and Disability Services Standards NZS8134:2021

Appendix A – Guidelines for Use of Sensory Rooms

Guidelines for Use of Sensory Rooms	
Tāngata whaiora involvement	The sensory room will be shown to tāngata whaiora as part of their orientation to the ward
	Tāngata whaiora will access the sensory room on a voluntary basis
	The use of the sensory room will be guided by an effective clinical process and clinical reasoning
	Tāngata whaiora are to be invited to complete the guest book kept in the Sensory Modulation Room (if applicable). The guest book provides information to help measure the effectiveness of the room, and to identify which modalities are most effective.
Staff responsibilities of registered staff and unregistered staff who have completed sensory modulation training and have been delegated sensory tasks	All staff members working with tāngata whaiora will be registered health professionals who have undertaken in-service education on sensory modulation when using the sensory room or sensory tools.
	At times delegation of the supervision of sensory modulation sessions to unregistered staff members occurs. In these circumstances the responsibility must be given under the direction and delegation of a registered health professional. The decision to delegate must be clinically driven at all times. Where the supervision of sensory modulation is delegated, the person using the sensory modulation intervention must have already been approved for sensory modulation treatment and be familiar with the room, the equipment and aware of the most effective treatment regime.
	When using the sensory modulation room with tāngata whaiora, staff should not be interrupted unless in an emergency.
Sensory Room requirements	Sensory rooms may be a multi-use space tāngata whaiora may access for reasons other than sensory modulation, often alone time. When the room is accessed for a reason other than sensory modulation, sensory tools are suitably locked away. At all times use of sensory rooms is assessed based on individual risk.
	For safety purposes, the sensory room must be locked at all times between uses. This is to manage risk factors of items kept in the room – combined with the pre-requisite that a trained staff member is present at all times to support people using the room.
	Access to the sensory modulation room is 'as available' or through pre-booking a regular treatment time in the diary. In the event of pre-booking, half hour gaps must be left available for urgent PRN use. This will ensure the maximum time a person may wait for access to the room during an acute

	clinical need is 30 minutes. The registered nurse and / or occupational therapist will determine priority of clinical need if required.
	Any additional sensory equipment must not be brought into the room and no sensory equipment will be removed from the room, without having been previously discussed with the responsible staff.
	Sensory modulation equipment must be stored in a secure safe place. Sensory trolley keys are stored in appropriate locations for each team / ward.
	Electrical equipment will be regularly checked and services as per requirement.
	The room must be left in a clean and orderly condition.
	An inventory of sensory modulation equipment is kept for each team.
Infection Prevention and Control requirements	Staff must adhere to the Infection Prevention and Control procedures regarding the cleaning of all items.
	All tāngata whaiora and staff must clean hands with an antibacterial hand rub on entering and exiting the sensory modulation room.
	A clean hospital towel must cover the massage chair inserts when in use.
	Sensory modulation equipment must be cleaned as per cleaning schedule.
	Surfaces are to be cleaned and disinfected between each use with V- wipes or alternatively with diluted hyposal – 10 mls hyposal in a litre of water.
	Sensory modulation equipment that is cracked, broken, chipped or in poor repair should be given to the Occupational Therapist who will decide on the course of action, i.e. repair or discard the item. This will also ensure monitoring of activities / equipment life and therefore usefulness.
	When purchasing sensory modulation equipment consider whether the item can be cleaned or disinfected between uses. Seek advice and guidance from Infection Prevention and control on equipment suitability.

Appendix B – Guidelines for the Use of Weighted Blankets

Guidelines for the Use of Weighted Blankets	
The following guidelines must be used in conjunction with the clinical reasoning of health care professionals who are skilled and trained in the use of weighted blankets. These guidelines will provide the rationale for the use, safety considerations, cleaning and maintenance of the weighted blankets.	
Tāngata whaiora involvement	Voluntary Use: The weighted blanket is never to be used as a restraint, the person must be willing to use/trial the weighted blanket.
	A variety of weighted modalities are available for individual use, the following factors must be considered: • Collaboratively determine initial plan for use with the tāngata whaiora and appropriately trained staff • Tāngata whaiora spine needs to be appropriately supported prior to weighted blanket use • Tāngata whaiora may choose to utilise the weighted blanket in a sitting or lying position. If in a lying position, respiratory function must be unimpeded. • Have the tāngata whaiora trial the use of the weighted modality, at their self-preferred amount of weight and in the positioning of their choice • Remind the tāngata whaiora that they can remove it at any time, especially if it becomes too heavy or too hot. • The tāngata whaiora must be able to remove the weighted blanket at will. • Consider climate / temperature and whether this will affect the person using the weighted blanket
	Every time either a weighted or light blanket is used, a hospital drawsheet must be used under it to protect the blanket from direct contact with the person.
Staff responsibilities	The use of weighted modalities will be indicated following assessment by appropriately trained staff.
	Staff need to use caution and good clinical judgement when introducing a weighted modality.

	Staff need to review each person's medial and trauma history. Some people who have experienced trauma will experience a sense of being trapped and have an adverse reaction to the use of a weighted modality.
	Weighted blankets must never be used over heads.
	Medical clearance may be required prior to use of weighted modalities Medical clearance will be documented in clinical records If not medically cleared, an alert will be placed in the tāngata whaiora clinical records not to use the Weighted Blanket. If the tāngata whaiora then asks to use the Weighted Blanket, the appropriately trained staff will determine the clinical appropriateness of the use.
Contraindications	Tāngata whaiora presenting with any of the following contra-indications will require vital signs monitoring (before, during and after use) and additional observations for safe use (before, during and after use). There are some people who will not be able to use weighted modalities due to general medical conditions, including the following: 1. Respiratory precautions 2. History of cardiac or circulatory problems 3. Skin integrity issues including open wounds or fragile skin 4. Heavy lifting precautions 5. Orthopaedic concerns: broken or fractured bones 6. Pregnancy If in doubt, seek medical clearance from doctor.
Transportation of weighted blankets	If blankets need to be transported out of the room for cleaning purposes, never carry weighted blankets weighing more than 10% of their body weight for ergonomic reasons. A trolley may be used to transport weighted blankets.

Appendix C - Infection Prevention and Control – Key expectations

Infection Prevention and Control – Key expectations	
To ensure Sensory Modulation Equipment is kept clean and fit for its purpose, all staff should be abide by the following key points:	
1.	Before and after using sensory modulation equipment, staff and tāngata whaiora must perform hand hygiene using antibacterial hand rub.
2.	Antibacterial hand rub must be available at the entry to any Sensory Rooms. (Availability of antibacterial hand rub is to be the responsibility of the staff member rostered on the cleaning schedule).
3.	Sensory modulation equipment must come into contact with intact skin only.
4.	A person who is visibly dirty should not be allowed to use the sensory modulation equipment.
5.	Where clothing is soiled or might be soiled, a sheet, or paper sheet or similar should be placed between the person and the sensory modulation equipment. Any sheets (or washable items) should be sent to the contracted laundry service via the usual procedures.
6.	Any hard surfaces of sensory modulation equipment are to be cleaned and disinfected after each use as per the equipment cleaning schedule.
7.	Any fabric covers on sensory modulation equipment are routinely laundered (either on-site by private arrangement, or by arrangement with contracted laundry services depending on local arrangements).
8.	Tactile sensory equipment / items that are difficult to clean and disinfect between uses (and/or are purchased from the $2 or $5 shops) must not be shared between tāngata whaiora. These items should be purchased, stored and dedicated for individual tāngata whaiora; the items can either be discarded or gifted to the individual on their discharge.
9.	For weighted blankets with covers, all blankets/weights must be removed prior to laundering. Blankets/weights should be stored in an appropriate location whilst covers are being laundered. These should also be cleaned if soiled.
10.	Responsibilities for cleaning schedules must be clearly defined, documented and available. Responsibility for cleaning schedules is likely to be delegated by the team manager.

Appendix D – Guidelines for the Safe Use of Essential Oils for Aroma Based Sensory Modulation

Guidelines for the Safe Use of Essential Oils for Aroma Based Sensory Modulation

These guidelines have been formulated to provide clear structure for the use of essential oils for aroma based sensory modulation. The dose of oil absorbed by the tāngata whaiora during sensory modulation should be so low that it does not cause any direct pharmacological effect and therefore this use of essential oils is not addressed by the Te Whatu Ora Waikato Medicines Management Policy. However caution is still required and all tāngata whaiora must have a medical assessment prior, and the responsible doctor must give approval before starting this therapy.

For the purpose of sensory modulation essential oils will be used to enhance and engage the olfactory sense for emotional regulation and therefore enhance engagement and participation in life roles.

People respond differently to different smells, so individuals should trial different smells and explore preferences. The method of exploring personal choice of oils to smell will be achieved by providing a sample of the essential oil via a couple of drops of oil onto cotton wool in a small pottle. The tāngata whaiora will not be provided with the essential oil bottle undiluted or directly to smell.

Essential oils will only be used through an electric aromatherapy oil burner or as a scent on cotton wool in a small pottle.

Following clear risk assessment the pottles with scented cotton wool may be provided to the tāngata whaiora for individualised and agreed use.

The following guidelines must be used in conjunction with the clinical reasoning of health care professionals who have knowledge of safe use of essential oils.

Assessment	Review each tāngata whaiora medical history for any medical conditions that would affect utilising essential oils. (Asthma, skin sensitivities, pregnancy etc.)
Essential oils approved for use at Te Whatu Ora Waikato	Essential oils for the purpose of aroma based sensory modulation will include: Sweet orange, lavender, bergamot, lemon grass, lemon oil and peppermint. For guidance on Use of these specific Essential Oils – see Appendix 5
Application method and use	Vapourise 2-7 drops onto water in a suitable electric aromatherapy oil burner 2-3 drops on cotton wool in small pottle
Handling Essential Oils	Do not apply undiluted essential oils directly to the skin, especially avoid contact with eyes and skin around the eyes Always wash hands after handling undiluted essential oils Take care not to get any essential oils into eyes or onto any mucous membranes

Storage	Essential oils are to be stored in the locked carts or locked cupboards Store in well-fitted airtight amber glass bottles at a temperature not exceeding 25 degrees C Protect from light Essential oils will be replaced annually or within expiry date or if there is any obvious product deterioration (e.g. cloudy or dark oil colour, or alteration in smell) In-use expiry: maximum of 12 months from date of opening, if shorter as stated in specific essential oil descriptor
Precautions	Use the minimum quantity of essential oil Use of essential oils for the purpose of aroma based sensory modulation should be avoided in people who: are pregnant or breast feeding. If the person is pregnant, medical advice must be sought from the tāngata whaiora GP or midwife before using essential oils asthma or known allergies / sensitivities May irritate skin, eye and mucous membranes (people using the oil and people in the vicinity) May trigger respiratory difficulties, asthma or migraines in susceptible individuals who are sensitive to odours Any suspected adverse reaction to essential oils should be reported in accordance with the Te Whatu Ora Waikato Medicines Management Policy (0138) and Clinical Records Management Policy (0182)
Contraindications & adverse effects	Hypersensitivity or allergy to any essential oil or its constituents
Toxicity	Medical assessment and observation is recommended for symptomatic tāngata whaiora following small ingestions and significant symptomatic skin exposures and all eye exposures. For further information refer to http://toxinz.com *Ingestion:* small ingestions should not normally require treatment. Aspiration may occur regardless of amount ingested. Administration of oral fluids and decontamination is not recommended due to risk of vomiting and pulmonary aspiration. *Eye:* irrigate immediately. Full eye examination should be undertaken *Skin:* remove contaminated clothing or jewellery. Area should be blotted with tissue to remove the oil, repeat this step if required. Wash affected area thoroughly with soapy water. *Inhalation:* remove tāngata whaiora from the exposure. Provide fresh air.

Flammability	Staff members supporting tāngata whaiora in sensory modulation will observe and be responsible for the use of specified electric aromatherapy oil burners for essential oils at all times. Only use electric oil burners with timers and always use these timers (typically a timer should be set for 15-30 minutes or less). Many essential oils are flammable, so never use or put bottles of essential oil near any other source of heat.

Appendix E

Refer to Appendix D for information on application method, dose, storage, precautions and contraindications.

Pharmacy Disclaimer

This guide has been prepared by Te Whatu Ora Waikato Medicine Information Service for use by Te Whatu Ora Waikato staff to support the use of sensory modulation as a therapeutic intervention.

Name	**Bergamot**
Botanical name (plant part used)	Citrus bergamia (zest or peel)
Appearance/ Properties	Light coloured (clear to pale yellow) oil with a sweet citrus aroma and top note.
Uses	Aroma based sensory modulation for calming and relaxing

Name	**Lavender**
Botanical name (plant part used)	Lavandula angustifolia (flowers, leaves and stems)
Appearance/ Properties	Thin essential oil, almost colourless with a sweet, floral scent and top note.
Uses	Aroma based sensory modulation for calming and relaxing.

Name	**Lemongrass oil**
Botanical name (plant part used)	Cymbopogon citratus (dried leaves)
Appearance/ Properties	Lemony, sweet smell and is dark yellow to amber and reddish in colour, with a thin consistency
Uses	Aroma based sensory modulation for calming and relaxing

Name	**Lemon oil**
Botanical name (plant part used)	Citrus limonum (fruit peel or zest)
Appearance/ Properties	Has a sharp, fresh smell, is pale greenish-yellow in colour and is watery in viscosity
Uses	Aroma based sensory modulation for calming and relaxing
Storage	Has a shorter shelf-life, 8-10 months only

Name	Sweet Orange oil
Botanical name (plant part used)	Citrus sinensis (fruit peel)
Appearance/ Properties	Clear, pale yellow to orange in colour and watery in viscosity. Has a sweet, fresh and tangy smell.
Uses	Aroma based sensory modulation for calming and relaxing and improving mood.

Name	Peppermint oil
Botanical name (plant part used)	Mentha piperita (flowering plant)
Appearance/ Properties	Thin oil. Light yellow to clear in colour. Aroma is fresh and has a menthol smell with a hint of woody undertones.
Uses	Aroma based sensory modulation for alerting and stimulating, mental agility and improving concentration.

Name	Sandalwood oil
Botanical name (plant part used)	Santalum album from the Santalaceae family (wood)
Appearance/ Properties	Oil is thick in viscosity and has a very light yellow colour. It has a warm, woody sweet aroma.
Uses	Aroma based sensory modulation for calming and relaxing

Waikato District Health Board

Protocol

Service user / Tangata whaiora Participation

Protocol Responsibilities and Authorisation

Department Responsible for Protocol	Mental Health and Addictions
Document Facilitator Name	Nicola Livingston
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff in the Mental Health and Addictions service
Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.	

Protocol Review History

Version	Updated by	Date Updated	Summary of Changes
05	Rachael Aitchison	25.11.15	Inclusion of freedom from discrimination, coercion, harassment, or other exploitation of consumers and recovery advisor positions
06	Nicola Livingston	6 May 2019	Changed from policy to protocol format

Service user / Tangata whaiora Participation

Contents

Service user / Tangata whaiora Participation

1 Overview

1.1 Purpose

This document outlines principles and practices of service user / tangata whaiora participation at Waikato District Health Board (Waikato DHB) Mental Health & Addictions Service (MH&AS). These principles and practices will ensure employees work inclusively with service users / tangata whaiora and their whānau (see Whānau Participation Protocol) as active partners at all levels of the service, having input into the treatment and services they use.

Participation reflects cultural choices, partnership, empowerment and the following recovery principles:

- Hope
- Personal responsibility
- Personal meaning
- Self-advocacy/choice
- Support
- Education

This document has a direct relationship to the WDHB Consumer Engagement Framework. The Consumer Engagement Framework for Waikato DHB comprises a set of principles, models and requirements for successful engagement.

In the Health & Disability Services standards the term consumers is used. Consumer is defined as ‘A person who uses / receives a health and disability service’. Instead of consumer, this protocol uses the term service user / tangata whaiora to reflect the language used in mental health & addictions services.

1.2 Scope

Service user / tangata whaiora engagement and partnership is inextricably linked to service

user / tangata whaiora experience and supports the delivery of person-centred care which is kind and compassionate. Service user / tangata whaiora engagement is essential to the development and delivery of mental health and addictions services through the active engagement of service user / tangata whaiora in the following:

- Person and whānau centred care
- Organisational responsiveness
- Policy and governance
- Shared decision making
- Service design and evaluation

1.3 Patient / client group

All MHAS Service users / tangata whaiora (community and inpatient) including children, young persons and/or vulnerable dependent adults.

1.4 Exceptions / contraindications

Nil exclusions

1.5 Definitions

Service user Participation at an individual level	The process of engaging and involving mental health service users in decision-making about their own health care at an individual level. The individual is supported by the services to achieve the life they want
Recovery Advisor	Waikato DHB employs a Recovery Advisor who works within mental health and addiction services supporting executive management, operational and service delivery teams to ensure the voices and experiences of people who use those services create a greater awareness and understanding of the various levels of service user / tangata whaiora participation and influence. Along with a recovery advisor employed by WDHB, other consumer advisors employed by Non-government organisation (NGO) operate as independent contractors to MH&AS, to ensure the delivery of advice, education and specific workforce requirements.
Consumer Advocate	An advocate is an independent person from an external agency who can listen to service users / tangata whaiora concerns and then advocate on their behalf
Tangata whaiora	People with experience of mental illness, who are seeking wellness, or recovery of self. Literally translated as people seeking wellness.
Recovery	Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience
Partnership	Authentic two-way relationship that values the lived perspective alongside clinical, managerial and other perspectives
Co-Design	Co-Design is a process which involves 'doing it together' from the start to the finish, namely, engaging with consumers, providers and other stakeholders to capture their experiences of services. Tools are used to gather information to understand these experiences, then consumers, providers and other stakeholders work together in a process to improve services. (Health Quality and Safety Commission Accessed: 5 February 2020)

2 Clinical Management

2.1 Roles and Responsibilities

All Staff

All Mental Health and Addictions staff are required to:

- Respect service user / tangata whaiora experiences and acknowledge that these play a significant role in their recovery.
- Ensure that every service user / tangata whaiora has the right to be free from discrimination, coercion, harassment, sexual, financial or other exploitation while using Mental Health and Addictions services. Service users / tangata whaiora may be more

vulnerable at times to discrimination, coercion or harassment because of varying levels of wellness.

- Provide an environment and culture free from discrimination, coercion, harassment, or exploitation from other service users / tangata whaiora or staff.

Coercion is an act by a person or persons against the will or without the permission of another human being with respect to that which is his own (his own person or property).

Discrimination occurs when a person is treated differently from another person in the same or similar circumstances based on past, present, associated or assumed characteristics.

Clinicians

All clinicians are required to work in partnership with service users / tangata whaiora to make informed choices in the planning, implementation and review of their treatment. This is inclusive of any relevant documentation.

At first contact, clinicians negotiate with the service user / tangata whaiora ways in which they can participate in their recovery process through assessment, recovery support, planning, implementation and review. At all subsequent contacts the clinician must ensure service users / tangata whaiora are able to participate in their recovery process.

All clinicians are expected to:

- Establish connection and rapport with the service user / tangata whaiora in such a way that they feel understood, listened to, supported and included in their care and treatment
- Ensure service users / tangata whaiora are enabled / encouraged to include their whānau and/or other supports at all times in their recovery
- Ensure access to cultural support
- Find out whether service users / tangata whaiora are parents and facilitate access to parenting support if required along with appropriate supports for children and young persons
- Address abuse or neglect concerns for children, young persons and vulnerable adults with appropriate services

Managers and Clinical Leaders

All management and clinical leaders are expected to support, resource, champion and role model consumer engagement within the service.

Recovery Advisor

A recovery advisor is available to all Mental Health Staff. Recovery advisor roles are responsible for ensuring service users / tangata whaiora are involved at all levels of the

organisation, fostering an environment of partnership which reflects recovery principles. A recovery advisor is involved in facilitating education and staff development / training to support person-centred, culturally responsive, recovery focussed whānau inclusive practice. Recovery advisors also provide advocacy and support to service users / tangata whaiora.

2.2 Competency required

All staff working in the MHAS are responsible for ensuring their practice is up to date with appropriate learning about working in partnership with service users / tangata whaiora. This includes, but is not limited to, attendance at regular education forums.

2.3 Equipment

IT electronic devices including, but not limited to, ipads used in Real Time Feedback.

2.4 Protocol

All Mental Health and Addictions service users / tangata whaiora can expect to:

- Be listened to
- Treated with dignity and respect
- Have their rights upheld by all employees of the MH&A service
- Receive information relating to their illness, treatment and rights
- Be given opportunities to make decisions regarding their healthcare.
- Have access to information to enable their participation in their treatment.
- Be given opportunities to provide feedback about the service they receive

Service users / tangata whaiora will be supported / enabled to develop an advance directive and either be directly supported by clinicians or be referred to a recovery advisor to support them in this process.

Service users / tangata whaiora are able to provide feedback on their experience of MH & AS through consumer feedback mechanisms, including Real Time Feedback, focus groups, post-seclusion debriefs and the compliments / complaint process. Recommendations from feedback will be given directly to teams / service areas and / or added to quality plans and service improvement activities.

MH&AS staff will have access to training, education and resources on working with and supporting service users / tangata whaiora and their whānau and can access the recovery advisor for support and advice.

Service users / tangata whaiora will participate in the development, planning, implementation, monitoring and review of service delivery, initiatives and change processes via the recovery advisor's involvement in the following:

- Providing strategic advice to executive management

- Development and monitoring of specific service user procedures and protocols around participation, service planning and service development
- Recommending innovations and contributing to quality improvement initiatives that will enhance service user experience
- Building relationships and connections with people across the organisation and externally
- Membership of key groups such as clinical governance, serious & sentinel events reviews, seclusion elimination, recovery planning where service user / tangata whaiora experiences and service delivery are the focus
- Development, monitoring, evaluation and feedback on service provision via mechanisms such as, but not limited to, Real Time Feedback, compliments and complaints and quality improvement reviews
- Ensuring co-design of service delivery initiatives occurs in line with co-design methodology

3 Patient information

Clinicians ensure the service user / tangata whaiora and whānau are informed of their rights under the Code of Health and Disability Services Consumers Rights. In the community and inpatient services people are provided with verbal and written explanations of their rights in accordance with the Privacy Code 1993 and the Health Information Privacy Code 1994 and the Code of Health and Disability Services Consumer Rights. Limits to confidentiality based on risk of harm to self and others must also be outlined along with the consent process.

Service users / tangata whaiora will be given information outlining what they can expect from the MH&AS, including roles and responsibilities of clinicians / key workers, contact information and how to seek support, and how they can participate in service development via feedback mechanisms.

All clinical areas will have displayed and have written information easily accessible on the following:

- Code of Health and Disability Services Consumer Rights
- Nationwide Health and Disability Advocacy Service
- Feedback, compliment and complaint processes
- Advance Directives
- Supporting Families Waikato, PROP, service user groups, Peer led services such as Centre 401

4 Audit

4.1 Indicators

- Real Time Feedback surveys being completed
- Recovery plans audit

5 Evidence base

5.1 References

- Health Quality and Safety Commission New Zealand Engaging with Consumers A guide for district health boards 2015
- New Zealand Guidelines Group 'Effective Voice and Participation for New Zealand' (2004).
- Ministry of Health's 'A Guide to effective Consumer Participation in Mental Health Services' (April 1995).
- Mental Health Commission. Blueprint for mental health services in New Zealand: How things need to be. Wellington: Mental Health Commission, 1998.
- Mental Health Commission. Our Lives in 2014 – A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors. Wellington: Mental Health Commission, 2004

5.2 External Standards

- Health and Disability Services (Core) Standards NZS 8134.1:2008

5.3 Legislation:

Waikato DHB must comply with the following legislation (this list is not exclusive):

- Health and Safety at Work Act 2015
- Human Rights Act 1993
- Privacy Act 1993
- Employee Relations Act 2000
- Treaty of Waitangi Act 1975
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment Act 1999
- Code of Health and Disability Services Consumers' Rights Act 1994

5.4 Associated Waikato DHB Documents

- Waikato DHB MH&AS Advanced Directive procedure (2181)
- Waikato DHB MH&AS Family / Whānau Participation policy (0896)
- Waikato DHB Consumer Feedback and Complaints policy (0101)
- Waikato DHB Incident Management Policy (0104)
- Waikato DHB Consumer Engagement Framework

Appendix A

Specific suite of services and scope for External Recovery Advisors

- Real Time feedback- Facilitate feedback opportunities for service users / tangata whaiora by using the electronic tablets for inpatient and community mental health
- Education facilitation - Recovery Educators from Progress to Health deliver recovery education to tangata whaiora in Puawai Forensic Service and the inpatient adult mental health services
- Puawai Midland Regional Forensic services facilitation at ward meeting and forensic clinical governance membership
- Provides systemic advocacy to improve outcomes for tangata whaiora to seek feedback from service user / tangata whaiora about the services they have received.
- Consumer Roles Advisory Board
- Ability to meet one off requests for policy review, service development etc.: under the direction on the Consumer Development Advisor

A peer support worker from a Non-Government Organisation (NGO), Centre 401, for past and present users of mental health services attends ward meetings on a Friday to promote the activities at their service.

Appendix B

Specialist Consumer Workforce Competencies Resource 2014

This resource has been funded and developed by Te Pou, Northern Regional Alliance and Midland HealthShare Ltd, in consultation with the wider consumer networks, the consumer/service user/peer workforce competencies is a guide for mental health and addiction services that employ people in identified lived experience roles. It is designed to be used in conjunction with the competencies for the mental health and addiction guide for managers / employers, and funding and planning. See links below.

http://www.tepou.co.nz/uploads/files/resource-assets/peer-support-competencies-2014.pdf
http://www.tepou.co.nz/uploads/files/resource-assets/service-user-consumer-and-peer-workforce-guide-for-planners-and-funders.pdf
http://www.tepou.co.nz/uploads/files/resource-assets/service-user-consumer-and-peer-support-workforce-a-guide-for-managers-and-employers.pdf

Sexual Safety on Inpatient Units

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Inpatient unit staff
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Te Whatu Ora Health New Zealand assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
2.0	Kylie Balzer	October 2023	Acute inpatient changed to mental health inpatient Added clinical staff responsibility to ensure that the physical health needs of tāngata whaiora are addressed Inclusion of supported decision making

Sexual Safety on Inpatient Units

Contents

Sexual Safety on Inpatient Units

1 Overview

1.1 Introduction

Mental Health and Addictions Service (MH&AS) is committed to recognising and responding to diversity and improving the mental health and wellbeing of all tāngata whaiora; this includes promoting sexual safety and sexual health.

All people have the right to feel and be sexually safe when accessing mental health inpatient treatment. Mental health services have an obligation to provide a safe, therapeutic environment for all tāngata whaiora and to take all reasonable steps to ensure that people's sexual safety is maintained. Services need to recognise the prevalence of trauma among people accessing mental health inpatient facilities.

All tāngata whaiora, staff and visitors have the right to a safe environment in adult inpatient services.

Our attitudes and the service's response to the disclosure of an alleged breach of sexual safety can significantly impact a tāngata whaiora experience and longer term well-being. Therefore, any allegation of an alleged breach of sexual safety is a serious matter and a consistent approach needs to be taken to the assessment, recording, reporting and follow-up of allegations. A failure to take a trauma-informed approach to care can also trigger re-experiencing of past trauma.

Staff may become accustomed to sexualised ideas, comments and behaviour within a mental health inpatient setting and may attribute a tāngata whaiora complaint of an alleged breach of sexual safety to their mental illness. At times it may be difficult to decide when to involve police, particularly when those tāngata whaiora involved are acutely unwell.

A tāngata whaiora may not know how to make a complaint about an alleged breach of sexual safety, and some may not recognise what constitutes a breach. When a tāngata whaiora sexual safety is allegedly breached in an inpatient environment, they may find it difficult to disclose the event for fear of perceived repercussions. Staff should be mindful that a tāngata whaiora may require support to pursue an allegation because perceived power relationships may leave the tāngata whaiora reluctant or unable to do so.

Tāngata whaiora may disclose allegations of sexual abuse / assault either as an inpatient or post discharge. Follow up post discharge will follow the complaints process aligned with this procedure.

The following procedure guides staff to manage alleged sexual safety breaches to support a safe environment.

1.2 Purpose

This document sets out the expectations for staff within the mental health inpatient services to:

- Promote, maintain and foster the sexual safety and sexual health of tāngata whaiora admitted to inpatient mental health services;
- Identify and appropriately respond to sexual safety risks;
- Respond appropriately to alleged breaches of sexual safety.

1.3 Staff group

Includes all staff working with tāngata whaiora admitted to the Mental Health and Addictions Service inpatient services.

1.4 Patient / client group

All mental health and addictions tāngata whaiora who are inpatients.

1.5 Exceptions / contraindications

Nil

1.6 Definitions and acronyms

Consensual sexual activity	A tāngata whaiora consents to sexual activity if they do it actively, freely, voluntarily and consciously without being pressured into it and have the capacity to consent (NZ Police, 2017).
Sexual assault	"Sexual assault is a term used to describe a range of sex crimes committed against a person. It is any unwanted or forced sex act or behaviour that has happened without a person's consent" (NZ Police http://www.police.govt.nz/advice/sexual-assault/sexual-assault-and-consent).
Sexual disinhibition	"Poorly controlled behaviour of a sexual nature where thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person" (Mental Health Complaints Commission, 2018).
Sexual harassment	Any unwelcome or offensive sexual behaviour that is repeated, or is serious enough to have a harmful effect, or which contains an implied or overt promise of preferential treatment or an implied or over threat of detrimental treatment (Human Rights Act, section 62(2), 1993).
Sexual health	"A state of physical, emotional and social wellbeing related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all tāngata whaiora must be respected, protected and fulfilled" (World Health Organisation, 2010).
Sexual safety	"Feeling and being sexually safe in acute mental health inpatient environments, including being free from sexual activity, sexual harassment and alleged sexual assault" (Mental Health Complaints Commission, 2018).
Sexual safety breach	"An experience in which a tāngata whaiora is not, or does not feel, sexually safe, including experiences of sexual activity, sexual harassment and alleged sexual assault (Mental Health Complaints Commission, 2018). This includes being exposed to sexually disinhibited and inappropriate behaviours associated with mental un-wellness.

Trauma-informed care	"A trauma informed care approach orientates staff and systems towards the needs of people who have experienced trauma and best practice approaches that support recovery and prevent additional trauma" (Te Pou, 2017).

2 Clinical management

2.1 Roles and responsibilities

Team Leader / Charge Nurse Manager

- Ensure all team members are fully orientated to this procedure and adhere to its processes
- Take appropriate action to address alleged sexual safety breaches as a matter of urgency and report to the appropriate clinician/manager
- Promote a culture of sexual safety on the unit
- Provide appropriate direction to staff when responding to alleged sexual safety breaches.

Responsible Clinician / Doctor

- In collaboration with the team leader / charge nurse manager, coordinate the response to allegations of breaches of sexual safety regarding the tāngata whaiora
- Conduct a review within 24 hours of an allegation of a breach of sexual safety
- Determine the threshold for reporting allegations of breaches of sexual safety to the police on a case-by-case basis in accordance with legal requirements, this procedure and in consultation with the multidisciplinary team (MDT).

When an allegation of a potential crime has been made:

- Coordinate and oversee the response to an allegation, ensuring timely and accurate documentation in the clinical record
- Evaluate the tāngata whaiora capacity to consent to reporting to the police and appropriate follow-up
- Assess the role of the tāngata whaiora mental state in the allegation and discuss this with a senior medical officer.
- Decide in consultation with the tāngata whaiora and relevant others the reporting of an allegation to the police
- A Datix incident form must be completed
- Consider any immediate systemic or practice issues related to the incident, and inform the appropriate clinical / managerial personnel as appropriate.

Clinical staff

- Familiarise themselves with the content of this procedure and adhere to its requirements
- Promote sexual safety of all tāngata whaiora in inpatient services
- Staff should assist police to conduct their investigation and make themselves available as appropriate
- After the police have interviewed a tāngata whaiora, staff should also assess the impact of the interview process on the tāngata whaiora and any clinical implications arising from this, and take appropriate action to respond to the tāngata whaiora needs.
- Ensure that the physical health needs of tāngata whaiora are addressed.

2.2 Competency required

Competencies as per clinician's and manager's role requirements.

2.3 Equipment

- Clinical Workstation
- Datix incident reporting system

2.4 Procedure

Team Leader / Charge Nurse Manager

- Staff are required to be vigilant for any signs of sexual activity between tāngata whaiora and others and have a low threshold for raising their concerns with the clinical team
- Sexual relationships in a mental health inpatient unit are not permitted.

Physical Environment

- A tāngata whaiora will not be permitted to enter another tāngata whaiora bedroom
- Vulnerable tāngata whaiora will be allocated a bedroom that affords the greatest level of safety, e.g. near the nurses' office
- Same sex tāngata whaiora will be assigned adjacent bedrooms, wherever possible
- Where current environmental constraints allow, provide female specific lounge areas
- Staff will be aware of areas on the unit where visibility is reduced and monitor accordingly.
- Staff need to maintain awareness of safety in all areas of the ward.

Orientation to the Unit

On admission tāngata whaiora will be provided with information on the ward expectations.

Family and Whānau Involvement

- Next of kin of competent tāngata whaiora are only advised of sexual safety breaches with the express consent of the tāngata whaiora (subject to very limited exceptions)
- A decision about communication with the next of kin of tāngata whaiora who are considered not to have the capacity to consent is made by the responsible clinician which may include discussion with the DAMHS and District Inspector. A supported decision making process is advised as per the Ministry of Health guidance on "Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992" (2020) https://www.health.govt.nz/publication/human-rights-and-mental-health-compulsory-assessment-and-treatment-act-1992
- Whānau, as appropriate, should be assisted to support a tāngata whaiora who has reported allegedly experiencing sexual assault or harassment
- Staff should consider whether whānau may have been or continue to be the perpetrators of abuse, and this must be considered when organising whānau visits, approving / planning leave or arranging review meetings.

Assessment of Sexual Safety Risk

- A risk assessment related to all clinical risks, including sexual safety is completed as part of the admission assessment and planning, both on admission and throughout the admission.

Management of Identified Sexual Safety Risk

- An overall management plan for all risks, including sexual safety, will be developed in collaboration with the tāngata whaiora and their whānau (as appropriate) when allegations of vulnerability to a breach of sexual safety is identified (Appendix A - Considerations for identifying sexual risks in the overall risk plan)
- All staff must be aware of the recovery plan
- The recovery plan will be regularly reviewed by the treating team and as part of the multidisciplinary team meetings (Appendix B - Considerations for supporting the development of an overall recovery plan).

Sexual Safety Breaches

- Any breach of sexual safety occurring in the inpatient unit will be taken seriously and reported immediately to the team leader / charge nurse manager / responsible clinician
- Staff are required to be vigilant for any signs of sexual activity between tāngata whaiora. The threshold for raising their concerns with the clinical team must be low.
- A Datix incident notification must be completed.

Responding to sexual activity between tāngata whaiora

- Staff intervene immediately requesting that the sexual activity stop and request assistance from a senior clinician as required.

- If staff suspect sexual activity may not be consensual, follow procedures set out in section "Responding to allegations of breaches of sexual safety in the mental health inpatient service, including a potential crime (e.g. sexual assault)" of this document
- Staff create an opportunity for discussion with the tāngata whaiora involved
- Staff support and sensitively counsel those involved about the difficulty of assessing consent in a mental health inpatient setting and the inappropriateness of sexual activity on the unit.
- Review the tāngata whaiora mental state, risk and treatment plan
- The tāngata whaiora is to be offered a physical assessment as soon as practicable and when the tāngata whaiora is ready. Note, if the sexual activity has the potential to be reported as a potential crime, then the physical examination must be completed by an appropriately qualified medical practitioner, and occurs via the police.
- Identify strategies to reduce the likelihood of a recurrence
- Raise the incident with the treating clinical team
- Clearly document the incident in the clinical record and log a Datix incident notification.

Responding to allegations of breaches of sexual safety in the inpatient service, including a potential crime (e.g. sexual assault)

- All allegations of breaches of sexual safety, particularly sexual assault or harassment, must be taken seriously and followed up immediately
- Reporting a potential crime to the police in the absence of the tāngata whaiora consent (through refusal or lack of capacity to consent)[1] must be considered when any of the following occur:
  - there is evidence apart from the tāngata whaiora testimony of a potential crime
  - the tāngata whaiora suffered harm
  - the tāngata whaiora decision was made not to report and their reasons given
  - there is a threat from the perpetrator of future violence or abuse
- Any reporting needs to be done by the CNM / Unit Manager or delegate.
- When a decision is made not to report an allegation to the police, details of the clinical assessment and decision along with the rationale for not reporting must be fully documented in the clinical record. This decision needs to be supported by the SMO.
- Physical examinations for the purposes of obtaining evidence of a potential crime must only be undertaken by an appropriately qualified medical practitioner (normally this occurs through the police) and with the tāngata whaiora consent.

[1] "It is important to note that there is a distinction between fulfilling a duty to report a potential crime to police, and by doing so to protect other potential victims, and respecting an individual's wish to not participate in a police investigation. Both of these objectives can be achieved if a tāngata whaiora does not subsequently wish to pursue a police investigation" (Mental Health Complaints Commission, 2018)

Procedure:

- Assess the situation and ensure a safe environment for the tāngata whaiora, alleged perpetrator, other tāngata whaiora and staff
- Re-establish safety ensuring there is appropriate staff support
- Remove the alleged perpetrator to a safe environment to prevent contact with the tāngata whaiora. Transfer the alleged perpetrator to another unit if appropriate
- Notify the responsible clinician / doctor, nurse in charge / operational manager. If the incident is after hours notify the after-hours ACNM Bureau and on-call staff.
- Discuss with the Charge Nurse Manager / lead clinician / responsible clinician (or after hours SMO and/or after hours duty coordinator) and assess the tāngata whaiora and develop a management plan and/or update the current management plan
- The CNM / Unit Manager or delegate will discuss with the tāngata whaiora whether they wish to involve the police if there is an alleged / potential crime and notify the police according to service tāngata whaiora wishes
- Preserve any evidence following a potential crime as appropriate (see Appendix C for more information on preserving evidence)
- Assess needs of the other tāngata whaiora on the unit and consider options to ensure a safe unit environment
- If able, offer access to Victim Support and rape crisis services (as appropriate) and ensure that support is available to facilitate this. (The treating team will consider how best to facilitate access, particularly if the tāngata whaiora has no leave.)
- Obtain support for the tāngata whaiora, e.g. consumer advisor, whānau, kaumatua or cultural support, tāngata whaiora advocate, clinician or other tāngata whaiora of their choosing, during any interviews, as appropriate
- If appropriate the risk of infection or pregnancy should be discussed with the tāngata whaiora, and testing recommended
- A debriefing should be offered to those affected by the event to support those involved and facilitate the ongoing functioning of the unit
- Complete a Datix incident notification once safety has been re-established, and document all assessments and associated interventions in the appropriate tāngata whaiora' clinical record.

Allegations of sexual activity between a tāngata whaiora and staff

- Any allegation that an employee has engaged in sexual behaviour, or any observation of an employee behaving in inappropriate sexual behaviour with a tāngata whaiora, then the following procedure must be followed.
- Allegations or observations should be investigated by the CNM / Unit Manager in accordance with relevant human resource policies and guidance from senior manager and human resources.

Procedure:

- Staff will notify their line manager
- Line manager to notify the head of discipline of the staff member and operations manager
- Advise the tāngata whaiora and their whānau (if appropriate) of the obligation to follow up on the matter and provide appropriate support to the tāngata whaiora
- Report the matter to the team leader / charge nurse manager immediately
- Maintain confidentiality about the incident outside of the reporting obligations
- Accurately document all information provided and the action taken, and complete a Datix incident notification as soon as is practical.

2.5 Discharge and follow-up care

- Consideration must be given in discharge planning to the tāngata whaiora ongoing needs for support, therapies and referral to other agencies
- The handover between the inpatient and community team and discharge summary must clearly record any breaches of sexual safety and identify ongoing needs, how they must be met and, where relevant, particular vulnerabilities. There needs to be care on what is reported around clearly recording the breaches given the sensitivity of the matter.
- Specific referrals should be made where appropriate, e.g. ACC sensitive claims, health screening services or other relevant agencies.

3 Patient information

Tāngata whaiora will be advised of ward expectations which include not entering the bedrooms of other tāngata whaiora.

Vulnerable tāngata whaiora will be allocated a bedroom that affords the greatest level of safety, e.g. near the nurses' office.

4 Audit

4.1 Indicators

Documentation

- A Datix incident notification must be entered for all alleged and/or proven sexual safety breaches
- Clinical documentation is to include (but not limited to):
  - date, time, place and description of the alleged incident based on available and reported information

- any clinical assessments and interventions implemented following the alleged breach
- details on steps taken to preserve evidence (where relevant)
- all discussions with the tāngata whaiora including any referrals and follow-up
- the name of the alleged offender and any witnesses
- details of those tāngata whaiora notified of the incident.

Orientation, Supervision and Training

- All staff will be fully orientated to this procedure
- Charge nurse manager/team leaders will ensure that all staff maintain an awareness of this procedure to support a safe environment for tāngata whaiora.

4.2 Tools

Implementation and Monitoring Compliance with / Effectiveness of Document

- All sexual safety incidents will be reported by staff through the Datix incident system
- All incidents and complaints related to sexual safety will be monitored by the team leader / charge nurse manager
- Trends will be examined and reported to the appropriate clinical governance forum.

5 Evidence base

5.1 Bibliography / References

Related Documents:

- Asia Pacific Forum of National Human Rights Institutions and the United Nations Development Programme (2016) Promoting and protecting human rights in relation to sexual orientation, gender identity and sex characteristics: A manual for national human rights institutions. Available online at: http://www.asiapacificforum.net/media/resource.file/SOGI and Sex Characteristics Manual 86Y1pVM.pdf
- Council for Healthcare Regulatory Excellence (2009) Clear sexual boundaries between healthcare professionals and patients. Information for patients and carers. London: Council for Healthcare Regulatory Excellence.
- Department of Health (2009) Promoting Sexual Safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units. Chief Psychiatrist's Guideline. Victoria: Department of Health.
- Department of Health (2011) Service guideline on gender sensitivity and safety. Promoting a holistic approach to wellbeing. Victoria: Department of Health.
- Jennings (1994) The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioural health system.

Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

- Mental Health Complaints Commission (2018) "The right to be safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety project report." Available at Ensuring sexual safety in acute mental health inpatient units | Single Digital Presence Content Management System (mhcc.vic.gov.au). Last accessed 22 August 2023
- Ministry of Health guidance "Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992" (2020) https://www.health.govt.nz/publication/human-rights-and-mental-health-compulsory-assessment-and-treatment-act-1992
- New South Wales Government (2013) Sexual safety of mental health consumers guideline. NSW: Ministry of Health.
- New Zealand Police (2018) Sexual assault and consent available online at: http://www.police.govt.nz/advice/sexual-assault/sexual-assault-and-consent
- Royal Free Hampstead NHS Trust (undated) Transgender Guide for NHS Acute Hospital Trusts
- Te Pou Trauma informed care | Let's get real | Te Pou last accessed 22 August 2023
- World Health Organisation (2010) Developing sexual health programmes – a framework for action. Geneva: WHO.

5.2 Associated Te Whatu Ora Waikato Documents

- Clinical Records Management policy (0182)
- Code of Conduct policy (5674)
- Consumer Feedback and Complaints policy (0101)
- Health Information Privacy policy (1976)
- Incident Management policy (0104)

Acknowledgements
This procedure has drawn on existing guidelines from New South Wales Government and Victorian Department of Health.

5.3 External Standards

- Ngā Paerewa Health and Disability Services Standards NZS8134:2021

5.4 Appendices

- Appendix A – Considerations for Identifying Sexual Safety Risks
- Appendix B – Developing a Management Plan
- Appendix C – Information for Preserving Evidence Following a Potential Crime

Appendix A – Considerations for Identifying Sexual Safety Risks

A risk assessment of sexual safety is part of the overall risk assessment for a tāngata whaiora. Some suggestions for incorporating risks related to sexual safety in an overall assessment may include (and are not limited to):

- Taking a sexual history including tāngata whaiora characteristics; trauma history; distress and social isolation; vulnerability associated with mental illness; sedation; physical inpatient environment; relational environment; influence of drugs and alcohol; sexually transmitted diseases and contraceptive status. **Careful consideration needs to be given when gathering sexual history as this could place tāngata whaiora and staff in a vulnerable position, and re-traumatise the individual.**
- The tāngata whaiora capacity to manage their sexual behaviour while in the unit (including their understanding of unit roles and assessment of insight into the possible consequences of breaches of sexual safety)
- The likelihood of the tāngata whaiora breaching sexual safety and the possible impact on other tāngata whaiora. Key factors to consider in the assessment include the form the behaviour takes and the context in which it occurs, including whether the behaviour is linked to their mental illness; the frequency of the behaviour; contributing factors or triggers; whether the behaviour is problematic and if so, to whom, and the risks associated with the behaviour. Clinicians will be mindful that a history of trauma is associated with the risk of perpetration of abuse of others, and the risk of being more vulnerable to exploitation. Consideration may need to be given to a forensic psychiatric assessment
- Any concerns relating to visitors that may contribute to the tāngata whaiora vulnerability to breaches of sexual safety.

Appendix B – Developing a Management Plan

The management of risks related to sexual safety for tāngata whaiora is part of the overall comprehensive management plan.

The following is suggested information and considerations to support the development of the overall comprehensive management plan:

- A tāngata whaiora with a history of trauma or abuse may be fearful of going to sleep at night or being in close proximity to unwell or disinhibited tāngata whaiora. Staff need to be mindful of the tāngata whaiora need for privacy and sense of tāngata whaiora security
- The level of observations required
- The most appropriate bedroom allocation in relation to other tāngata whaiora and staff safety
- Maintaining clinical vigilance
- Increased vulnerability at particular times due to reduced staff availability, e.g. during handover, team meetings and night shifts
- Encouraging participation in unit activities to minimise isolation and vulnerability
- How to reinforce appropriate behaviour
- How to minimise re-traumatisation for those who have experienced previous sexual assault
- Talking to whānau (as appropriate) about how best to understand and respond to their whānau member who may be, for example, acting in a sexually disinhibited way
- Reviewing an advance directive that may be available to inform care
- Ensuring the person is adequately clothed or afforded privacy at all times
- Changes required to the environment to provide safety for other tāngata whaiora and staff, including segregating or removing the suspected perpetrator from the victim's vicinity (which will also provide a more appropriate and private therapeutic environment for the suspected perpetrator)
- How and what to communicate to the tāngata whaiora and their whānau about identified sexual risk and how it can be managed
- Assertive treatment of their acute symptoms and disturbed behaviour where a tāngata whaiora vulnerability to experiencing and/or breaching sexual safety is largely due to their mental state
- Post-incident support should be considered as part of the ongoing management plan
- Regular assessment throughout their admission and during transition periods, e.g. move from more restrictive setting to an open environment. Staff should be alert to the fact that tāngata whaiora who engage in sexually inappropriate activity may use subtle means of coercion, grooming and manipulation, not only overtly violent behaviour
- Communication with the tāngata whaiora should be assertive and direct about the rules of the unit, behavioural expectations, and the consequences of sexual behaviour such as psychological harm, pregnancy or infection, reporting to the police.

Appendix C – Information for Preserving Evidence Following a Potential Crime

- It is important to preserve any evidence of sexual assault and/or harassment in the event that the tāngata whaiora later chooses to lay a complaint with the police. Advice must be sought from the local police
- Generally the tāngata whaiora should be discouraged from changing their clothes or showering/bathing. The tāngata whaiora should be advised that changing clothes or showering may destroy evidence that could later be used in court proceedings. If the tāngata whaiora feels compelled to wash or change, the clothing they were wearing at the time should be secured in a bag and labelled
- The clothes will be securely stored until such time as the tāngata whaiora has decided to make a report to the police. If a report is going to be made to the police, advice should be sought from the police as to what to do with the clothing. If the tāngata whaiora does not wish to report the matter to the police, clothing should be returned to the tāngata whaiora or destroyed depending on the tāngata whaiora wishes
- Staff should record in the clinical record what evidence has been stored, who took it, how it has been secured and who the evidence has been handed to. The room where the alleged offence occurred should also be sealed off from use until such time as the tāngata whaiora has decided whether or not to make a report to the police, and if so, until police examination, where possible. The names and contact details of any potential witnesses to the assault should be documented.

Sexual Safety on Inpatient Units procedure – November 2023

Document Facilitator:	**Kylie Balzer**	**Date Prepared:**	

Actions	By Whom	By When	Resource	Evidence of Completion
Monitoring process Monitoring of incidents, complaints and feedback **Note this procedure will be put out for a shorter time period given that there is a current incident that will provide feedback to the service.** Monitoring of practice in inpatient areas	CNMs and Operations Manager Operations Manager and Clinical Director to define	20 Dec 2024	Staff time	Minutes of acute adult, forensic and MHSOP clinical governance Reports to acute adult, forensic and MHSOP clinical governance and minutes

Transport and Escort of tāngata whaiora

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions service staff
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
5	Kylie Balzer	November 2019	Change from policy to procedure template Review of procedure in line with other DHB procedures Inclusion of safety requirements for children Inclusion of transport by ambulance
6	Kylie Balzer	January 2023	Change to Te Whatu Ora Waikato procedure template Terminology changed to tāngata whaiora and whānau and based on feedback to the procedure Purpose of the procedure rewritten Exceptions section updated Clarification between Acute Care Transport and Transport for Rehabilitation / Therapeutic programme Clarification of decision making by a registered health professional

Transport and Escort of tāngata whaiora

Contents

Transport and Escort of tāngata whaiora

1 Overview

1.1 Purpose

The purpose of this procedure is to outline the requirements for the transport and escort of tāngata whaiora who are current or proposed tāngata whaiora of the mental health and addictions service. Transport and escort may occur:

- within the Te Whatu Ora campus
- externally to services / environments within the community
- externally to / from other Te Whatu Ora facilities
- from people's place of residence, community facilities to a Te Whatu Ora Waikato facility

It is essential that effective decision making occurs by registered health professionals, inclusive of Duly Authorised Officers in crisis situations to minimise any risks to tāngata whaiora, whānau, and the public. It is also necessary to make sure that the transport and escort of tāngata whaiora is carried out in a manner which is empowering for tāngata whaiora and whānau.

1.2 Staff group

This procedure applies to all Te Whatu Ora Waikato mental health and addictions staff involved in the transport and escort of Mental Health and Addictions tāngata whaiora.

1.3 Patient / client group

Mental Health and Addictions tāngata whaiora.

1.4 Exceptions / contraindications

For information on escorted leave without transport please see the Leave – Adult Mental Health inpatient wards procedure (2184) or the Leave – Puawai Inpatient wards procedure (6266) as appropriate to the context.

1.5 Definitions and acronyms

Duly Authorised Officer (DAO)	Duly authorised officer means a person who, under section 93, is authorised by the Director of Area Mental Health Services to perform the functions and exercise the powers conferred on duly authorised officers by or under the Mental Health (Compulsory Assessment and Treatment) Act 1992
Escort	Accompanying the tāngata whaiora while under the care of the mental health and addictions service or as a potential tāngata whaiora / service user
Transport	Providing the means of transfer of tāngata whaiora by vehicle for the purposes of mental health assessment / care provision

2 Clinical management

2.1 Roles and responsibilities

Clinical Staff
All clinical staff are required to understand their role and apply the practices outlined within this procedure in order to provide a safe environment for tāngata whaiora and staff in the transport and escort of tāngata whaiora and whānau members.

Managers
Managers are required to make sure that their staff are aware of the transport and escort of tāngata whaiora procedure and review any incidents.

2.2 Competency required

Staff providing transport and escort of tāngata whaiora must have the required health care competencies as per the individual context of transport and escort, and individual health care needs of the tāngata whaiora.

2.3 Equipment

- Te Whatu Ora Waikato vehicle
- Cell phone when transporting tāngata whaiora
- Radiotransmitter for Escorts

2.4 Procedure

2.4.1 Transportation and Escort Assessment

Before transporting any tāngata whaiora a transportation and escort assessment must be completed in consultation with people currently involved with the tāngata whaiora (e.g. Mental Health and Addictions service staff, whānau / friends where appropriate)

The assessment will consider the following:

- Purpose of travel and number of tāngata whaiora
- Time of day and distance to be travelled
- Mode of transportation available
- Tāngata whaiora characteristics: age, gender, culture, physical health; cooperation, current mental state
- Current risk assessment

2.4.2 Transportation Planning

A transportation plan will be developed for the transport of tāngata whaiora who are acutely unwell based on the assessed needs of the tāngata whaiora and the staffing resources required for appropriate and safe transportation of the tāngata whaiora.

a) Staffing requirements

b) Mode of transport

The plan will be communicated to the charge nurse manager / team leader or delegate

The plan will be documented in the progress notes in the tāngata whaiora clinical record.

Te Whatu Ora Waikato Vehicles

Child-proof lock

Te Whatu Ora Waikato vehicles must have the child-proof lock on the left rear door engaged at all times.

Transport

It is the responsibility of the driver to ensure appropriate passenger safety restraints are available and utilised. Seatbelts are to be worn by all passengers.

Children

Children over seven years old and measuring a height of 148cm may travel when secured by an adult seat belt. Smaller children must be secured in an approved restraint as follows:

Requirements for child restraints

Age of child	The law says you must:
Until their 7th birthday	Correctly secure your child in an approved child restraint
From their 7th to their 8th birthday	Correctly secure your child in an approved child restraint (and if not, in any child restraint or safety belt that is available)
From 8th birthday to 14 years old	Must use safety belts if available. If not available, they must travel in the back seat.
Over 14 years old	Must use safety belts where they are available.

Availability of Approved Child Restraints

Te Whatu Ora Waikato does not own approved child restraints. Where it is necessary to transport a baby or small infant and the parent is unable to provide the necessary resources, a taxi should be requested. The type of child restraint required must be specified when ordering the taxi.

Acute Care Transport

It is recommended that two staff accompany tāngata whaiora in Te Whatu Ora Waikato vehicles at all times (one driver and one escort) for tāngata whaiora who are acutely unwell. A driver of a vehicle cannot be an escort.

Tāngata whaiora are to travel in the left rear seat with a staff member seated beside them on the right. Any decision to alter this arrangement must only be following assessment of negligible risk to self or others by a registered health professional.

The transport plan will consider potential risks that may occur during transport and ensure that staff transporting the tāngata whaiora are aware of who to escalate any concerns to, which arise during travelling.

Rehabilitation / Therapeutic Programme Transport and Escort

For tāngata whaiora being transported and escorted as part of a therapeutic programme all decisions about transport and escort will be made with due consideration of risk, physical wellbeing and mental state by a registered health professional / the multidisciplinary team.

Any decision to transport a tāngata whaiora with a driver only must only occur following an assessment of negligible potential risk to self or others by a registered health professional.

Forensic Service Transport

Transport of tāngata whaiora under the care of the Forensic service is as agreed in the leave plan approved by the DAMHS.

Police Vehicles

General

Where a tāngata whaiora immediate risk to self or others is deemed to be high and this risk is unable to be managed by mental health staff, police assistance may be requested. This should be negotiated with the New Zealand Policy Communication centre. Refer to the Memorandum of Understanding between the Director of Area Mental Health Services and Police.

Mental Health Act Situations

Where police assistance is requested under Section 41 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, a DAO must accompany the tāngata whaiora or proposed tāngata whaiora at all times to monitor their physical state and address any concerns. This practice may only be bypassed in exceptional circumstances, in consultation with Police, where the risk can be safely managed by police, and it is in the best interests of the tāngata whaiora for the transport to be expedited in a timely manner, rather than waiting for the DAO to attend. Police remain responsible for managing the risk of violence towards self or others.

Where police assistance is not required – any tāngata whaiora or proposed tāngata whaiora – as identified under the Mental Health (Compulsory Assessment and Treatment) Act 1992 must be accompanied by a duly authorised officer (DAO) or delegate. Any delegation of proposed tāngata whaiora under the Mental Health Act sections 8-11 must only be to another registered health professional, and only after a clear and documented risk assessment. Under no circumstances can a whānau member or friend be delegated to transport a proposed tāngata whaiora under section 8-11 of the Mental Health Act without a registered health professional present.

Taxi / Shuttles

General

The use of a taxi / shuttle to transport tāngata whaiora may be considered under the following conditions:

- Vehicular transport is deemed to be clinically beneficial
- The tāngata whaiora is unable to access anyone to drive them
- The tāngata whaiora does not have sufficient funds to pay for a taxi
- The tāngata whaiora does not pose any risk to others

Ambulance

Medical Emergencies

Emergency equipment is not carried in Te Whatu Ora Waikato vehicles. No tāngata whaiora in a medically compromised state, or whose medical state may deteriorate rapidly, is to be transported in a Te Whatu Ora Waikato vehicle. An ambulance must be called.

Where the tāngata whaiora requires medical treatment at the Emergency Department, it is not necessary for mental health and addictions staff person to accompany them.

Transfers from mental health wards

When a tāngata whaiora is medically compromised, or is unable to be safely transported in a regular vehicle due to increased medical risk, e.g. positional asphyxia, an ambulance must be requested.

Any tāngata whaiora being transferred to a ward must be accompanied by an appropriate registered mental health professional.

Mental Health Act situations

Any tāngata whaiora or proposed tāngata whaiora – as identified under the Mental Health (Compulsory Assessment and Treatment) Act 1992 – must be accompanied by a duly authorised officer (DAO) or delegate, when transported by ambulance. The rationale for delegation, including the tāngata whaiora need for oversight must be documented.

Transport for assessment from the Ara Poutama Aotearoa Department of Corrections

Transport for assessment from the Ara Poutama Aotearoa Department of Corrections is as per the Ministry of Health Guidelines for the safe transport of special patients in the care of Regional Forensic Mental Health service. Transport arrangements are to be discussed with the DAMHS and the Director of Mental Health service.

Admission to Child and Family Unit (CFGU) Starship

A Duly Authorised Officer will transport young people under the age of 18 to Starship Hospital – Child Youth and Family Unit for admission under the MH (CAT) Act 1992, along with two other escorts. Other escorts may include: Parent or whānau member, Te Whatu Ora Waikato support worker, Agency Staff, Oranga Tamariki staff, NGO worker or police jailor (decided by the DAO).

For the transportation of young people under the age of 18 to Starship hospital for admission the Duly Authorised Officer must adhere to the requirements of the After Hours Assessment and Admission of Children and Youth to the Henry Rongomau Bennett Centre and Starship procedure (2768).

Informal admissions or assessment

Significant others may transport the tāngata whaiora to the inpatient facility for an informal admission or community location for assessment after consideration of the risks.

External transfers to another Te Whatu Ora facility

For transfers to another Te Whatu Ora facility the transportation plan will be arranged between the primary nurse, charge nurse manager / team leader and the responsible clinician with the principles of this procedure in mind.

3 Audit

3.1 Indicators

Transport and escort of tāngata whaiora is carried out in accordance with this procedure.

3.2 Tools

Incident reporting and management

4 Evidence base

4.1 Summary of Evidence, Review and Recommendations

- Bay of Plenty District Health Board Mental Health and Addiction Services Protocol Transportation of Tāngata Whaiora / Consumers Version 5
- Southern District Health Board Transporting Clients – Emergency Psychiatric Service (Otago) Version 4

4.2 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions After hour's admissions of children and youth to HRBC and Starship procedure (2768)
- Mental Health and Addictions AWOL (Absent without Official Leave) procedure (3555)
- Mental Health and Addictions Leave – Adult Mental Health inpatient wards procedure (2184)
- Mental Health and Addictions Leave – Puawai Inpatient wards procedure (6266)
- Mental Health and Addictions Levels of Observation in Inpatient Services procedure (5238)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Te Whatu Ora Waikato Clinical Records Management policy (0182)
- Te Whatu Ora Waikato Incident Management policy (0104)
- Te Whatu Ora Waikato Vehicle Usage and Safe Driving policy (0112)

4.3 External Standards

- Ministry of Health Guidelines for the safe transport of special patients in the care of Regional Forensic Mental Health Services (November 2022)
- Ngā Paerewa Health and disability services standard NZS8134:2021
- The New Zealand Rode Code
- Substance Addiction (Compulsory Assessment and treatment) Act 2017
- Human Rights Act 1993
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Land Transport NZ Fact Sheet 7 Feb 2005 Child Restraints
- Privacy Act 2020
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendments
- Criminal Procedures (Mentally Impaired Persons) Act 2003
- Intellectual Disability Compulsory Care and Rehabilitation Act 2003
- Memorandum of Understanding between the Ministry of Health and the Police

Use of Personal Restraint across Mental Health and Addictions Inpatient Settings, inclusive of OPR1

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
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Document Facilitator Title	Nurse Director Mental Health
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
05	Kylie Balzer	October 2015	Updated into new procedure template. Inclusion of non-use of restraint in Puna Whiti (previously procedure 1549)
	Areann Libline and Nicky Barlow	November 2015	Inclusion of panic button for Puna Whiti. Updating of monitoring information, terminology e.g. treatment changed to recovery, and documentation requirements
06	Carole Kennedy	May 2019	All changes made following consultation

Use of Personal Restraint across Mental Health and Addictions Inpatient Settings, inclusive of OPR1

Contents

1. Overview

1.1 Purpose

This procedure specifies the clinical practice requirements for the correct and safe use of personal restraint as an intervention used by inpatient staff for tāngata whaiora / service user / care recipients under either the Mental Health (Compulsory Assessment & Treatment) Act 1992 [MH (CAT) Act] or those care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 [ID(CC&R) Act] Section 60 (2), within an inpatient Mental Health & Addictions Service setting.

The procedure adheres to compliance as outlined within the Restraint Minimisation and Safe Practice Standards, NZS 8134.2:2008 and Waikato District Health Board (DHB) Restraint Policy (2162).

1.2 Scope

Applicable to Mental Health inpatient wards with the exception of Puna Whiti.

1.3 Patient / client group

Mental Health and Addictions service users / tāngata whaiora

1.4 Exceptions / contraindications

Personal restraint is not to be used in Puna Whiti; alternative interventions are to be used in situations that result in damage to persons or property. In some situations it may be necessary to use a radio transmitter or press one of the two panic buttons located in Puna Whiti to request support from staff throughout the Henry Rongomau Bennett Centre to assist or aid transfer of a client to another unit.

The police may be called when a resident of Puna Whiti:

- Seriously compromises the therapeutic environment (e.g. by damage to property) or assaults any other persons

Rationale:
The aim is to deal with challenging situations in the same way that would occur within a flatting situation in the community
To ensure the safety of all

1.5 Definitions

Good Practice:
The current accepted range of safe and reasonable actions that result in efficient and effective use of available resources to achieve quality outcomes and minimise risk for the consumer. Current accepted good practice should also reflect standards for service delivery this may include but is not limited to:

- Codes of practice;
- Research / evidence / experience based practice;
- Professional standards;

- Good practice guidelines;
- Recognised / approved guidelines; and
- Benchmarking.

NZS 8134.0:2008 Health and Disability Services (General) Standards, p.24)

Personal restraint

"Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider" (NZS 8134.0: 2008, Health and Disability Services (General) Standards, p.30). Tāngata whaiora / service users / can only be subject to the use of personal restraint when there is an assessed risk to the safety of the tāngata whaiora / service user, to other tāngata whaiora / service users, service providers, or others.

Restraint:

"The use of any intervention by a service provider that limits a consumer's normal freedom of movement". (NZS 8134.0:2008, Health and Disability Services (General) Standards, p.30).

Tāngata whaiora / service user / care recipient:

These terms are inclusive of those who identify as Māori; and care recipients.

Health professional is described as prescribed under the Health Practitioners Competency Act (2003) with a registered scope of practice.

2. Clinical Management

2.1 Competency required

All persons applying personal restraint MUST have achieved competency in Safe Practice Effective Communication (SPEC) training. Their training is captured on databases, specifically SPEC and is uploaded onto the staff member's educational (PeopleSoft) database. The use of personal restraint shall only be applied under the direction of a SPEC trained registered health professional. In case of an emergency/ unpredictable event a staff member who has completed SPEC can initiate to secure the environment, until a registered health professional arrives.

2.2 Equipment and personnel

A minimum of a three person restraint team who are trained in SPEC; and undertake two yearly SPEC update training, refresher 2 day competency course.

Duress alarm

Security responds to all duress alarm activations from OPR1 – as first responders.

2.3 Procedure

1. Action: Pre-restraint episode

Collaborative assessment(s) is based on clinical judgement, early intervention and de-escalation, continued evaluation to identify key factors which could lead to the possible use of personal restraint. Personal restraint is only applied as a last resort with the minimal amount of force, after alternative interventions have been considered or attempted and determined ineffective.

Rationale: Services shall ensure rigorous assessment of tāngata whaiora / service users is undertaken.

Kaitakawaenga and if appropriate, whānau involvement from the outset supports efforts to reduce Māori over-representation in personal restraint and seclusion.

2. Action: Indications for the use of personal restraint

Tāngata whaiora / service users can only be subject to the use of personal restraint when there is an assessed risk to the safety of the tāngata whaiora / service user, to other tāngata whaiora / service users, service providers, or others.

Rationale: Personal restraint should be applied only to enhance or maintain the safety of tāngata whaiora / service users, service providers or others.

3. Action: The decision to initiate personal restraint

Restraint is initiated only when there is a three person SPEC team assembled to ensure safe initiation, use and termination.

The responsible clinician (or delegate) must be contacted immediately of the clinical emergency and decision to use personal restraint.

The care manager (or delegate), if under the ID (CC&R) Act must be notified immediately within working hours of the clinical emergency and decision to use personal restraint. Email is generated outside of normal working hours.

The charge nurse manager, associate charge nurse manager or after hours nurse co-ordinator must be notified immediately.

The dignity of the restrained tāngata whaiora is maintained at all times by ensuring privacy and respect in their time of distress.

In the case of an emergency, risk of safety to self or others the duress alarm will be activated to secure the environment until a SPEC trained emergency response team arrive. For OPR1 service they await security to support.

Rationale: Service providers recognise and facilitate good practice and legal notification process.

To ensure adequate resource and environmental needs are available.

Psychiatric assistants work under the direction and delegation of a registered health professional.

4. Action: Implementation of personal restraint

Only staff with current competency in SPEC will be involved in the restraint process.

At least one registered nurse trained in SPEC must be present throughout the restraint cycle.

At least one person of the same gender as the tāngata whaiora / service user must be present throughout the restraint, swapped in the case of an emergency.

The tāngata whaiora / service user physical and psychological well-being is monitored by a registered nurse throughout the restraint process by direct monitoring of the airway, breathing and circulation. The person's dignity and privacy is maintained and the process of de-escalation, and active listening continues.

Rationale: The use of personal restraint is conducted in the safest, least restrictive and most appropriate manner, by trained staff, and this includes monitoring and evaluating the process.

5. Action: Communication

Communication is key, to provide the Tāngata whaiora / service users of the reasons why they are being placed in personal restraint and what needs to occur for the personal restraint to end.

Tāngata whaiora / service users (and where appropriate their family / whānau) must be informed of their rights and advocacy services in a timely way.

Rationale: Service providers communicate effectively with tāngata whaiora / service users.

Service providers recognise and facilitate the right of tāngata whaiora / service users to advocacy support persons of their choice.

The right of tāngata whaiora / service users to make a complaint is understood, respected and upheld. The health professional will provide them with the necessary information to make a complaint, if unresolved.

6. Action: Ending personal restraint

The decision to end personal restraint is made by the registered health professional following rigorous risk assessment and care / re-integration planning and feedback from the restraint team as to whether there are any concerns relating to the release of the holds.

Following the ending of personal restraint, the tāngata whaiora / service user / is given the opportunity to discuss the event and has access to support / advocacy.

Following the ending of personal restraint the personal restraint team must review the restraint episode (Diffusion). A senior nurse is appropriate to lead this activity.

Formal debrief to be arranged by the charge nurse manager if required.

Rationale: All clinical factors and safety issues are well considered.

Tāngata whaiora / service user rights and access to support and advocacy is adhered to.

Identify any learnings to promote best practice and reduce the risk of further personal restraints.

7. Action: Post-implementation of personal restraint

Once restraint is ended the registered nurse will:

Check if the tāngata whaiora / service user has incurred any injuries / re-traumatization and arrange treatment / support, this is noted in the clinical record. Datix is completed and medical assessment is requested.

Check if staff members have incurred any injuries/trauma and arrange treatment/support
Ensure that an opportunity for staff to discuss the incident is initiated – diffusion immediately following an event. Formal debrief may be considered and arranged.

Rationale: Safety needs and wellbeing of tāngata whaiora / service user and staff are met.

8. Action: Documentation

The registered health professional is responsible for the documentation of the personal restraint episode. This should include input from the restraint team members.

Documentation of each personal restraint episode will include:

- Details of reasons for initiating personal restraint, including the desired outcome
- Details of the alternative interventions including de-escalation techniques attempted prior to the use of personal restraint
- Details of each individual hold used, including 'prone position' and is recorded on the Restraint Event Notification Form (REN)

- Details of advocacy / support offered and provided
- The outcome of the personal restraint episode
- Observations and monitoring of the tāngata whaiora / service user during the personal restraint episode
- Completion of Waikato DHB restraint event notification (REN) form (T1738HWF)
- Completion of Datix electronic incident form detailing the incident that lead to personal restraint use
- Completion of Datix electronic incident form for any injury to any person as a result of the use of personal restraint
- Update Risk Assessment and formulation for the event
- Amend Recovery Plan to include early warning signs of escalation and interventions for de-escalation

Rationale: Each episode of restraint is documented in sufficient detail to provide an accurate account of the use of personal restraint AND inform recovery planning by ensuring early warning signs and methods of de-escalation are clearly documented.

Services evaluate all episodes of personal restraint with a view to reducing use of personal restraint.

9. Action: Evaluation

Each episode of personal restraint is evaluated by the personal restraint team, and any other staff involved: additionally evaluated in collaboration with the tāngata whaiora / service user, and their family / whānau (as appropriate).

Evaluation shall include:

- Whether the personal restraint episode was the least restrictive option to achieve the desired outcome
- The duration of the personal restraint episode and whether this was for the least amount of time required
- *The impact the personal restraint had on the tāngata whaiora / service user*
- Any identified triggers and the strategies to minimise / eliminate them are included in the tāngata whaiora /service user / multidisciplinary team treatment plan
- Whether the appropriate advocacy / support was provided or facilitated
- Whether the observations and monitoring were adequate and maintained the safety for the tāngata whaiora / service user

- Whether the tāngata whaiora / service users / multidisciplinary treatment plan was followed
- Whether the services policies and procedures were adhered too.

Rationale: Any new learning will support service improvement including changes in staff training, nursing practice and processes and procedures.

Recovery plans and risk tools are updated in response to the evaluation.

10. Action: Education

All inpatient nursing, occupational therapists, social workers and psychiatric assistant staff will receive full SPEC training and 2 yearly updates.

The Waikato DHB electronic Restraint Self Directed e learning, Restraint Minimisation and Safe Practice questionnaire is completed 3 yearly.

All inpatient registered health professional staff must have completed mandatory training related to legal frameworks, risk assessment, trauma informed care, Māori cultural practice and recovery.

All staff will have knowledge of "The Code of Health and Disability Service's users / tāngata whaiora Rights 1996", AND be able to assist tāngata whaiora / service users to access the information.

All staff have knowledge of human rights, scopes of practice, relevant legislation and relevant Waikato DHB policies and procedures including MH (CAT) Act 1992, IDDCR Act, CIP Act 2003.

All staff have knowledge of Tikanga Best Practice Guidelines.

Staff education records are maintained by the organisation.

Rationale: All inpatient registered health professionals and psychiatric assistant staff will have access to education and ongoing training on use of personal restraint, including relevant legislation and regulation, and cultural considerations related to the use of personal restraint.

3. Patient Information

Restraint pamphlet

4. Audit Indicators

4.1 Indicators

Use of personal restraint is audited at bimonthly monthly intervals to monitor compliance with Waikato DHB Restraint policy as per the restraint committee requirements.

4.2 Tools

Waikato DHB Restraint Event Notification form

Waikato DHB Restraint Committee Annual Audit

5. Evidence Base

5.1 References

- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards Restraint Minimisation NZS 8134.2:2008
- Nursing Council of New Zealand. (May 2011) Guideline: direction and delegation of care by a registered nurse to a health care assistant. Retrieved from *http://www.nursingcouncil.org.nz/index.php/content/download/.../nurse_delegation_RN.pdf*
- Te Pou o Te Whakaaro Nui Supporting organisations to develop their workforce – Hikitia! Hapainga! : Link to the following re https://www.tepou.co.nz/resources
- Towards restraint - free mental health practice: Supporting the reduction and prevention of personal restraint in mental health inpatient settings. (May 2015)
- Trauma – informed care resources
- Six Core strategies for reducing seclusion and restraint checklist

5.2 Associated Documents

- Waikato DHB Restraint Policy (2162)
- Waikato DHB Restraint Event Notification form T1738HWF
- Waikato DHB Incident management system (DATIX)
- Clinical workstation associated documents
- Waikato DHB Electronic Restraint Self Directed 2 Learning, Restraint Minimisation and Safe Practice questionnaire
- Safe Practice Effective Communication (SPEC) trainers handbook 2016
- Safe Practice Effective Communication (SPEC) participants workbook 2018
- Waikato DHB Tikanga Recommended Best Practice Guidelines (2118)
- Waikato DHB Management of employee Health and Rehabilitation Policy (0188)

Use of Purchasing Cards (P cards)

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rachael Aitchison
Document Owner Title	Director
Target Audience	Forensic staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
03	Kylie Balzer	20 June 2018	Changed into current DHB Guideline template Change in title from use of P cards to use of Purchasing cards
04	Kylie Balzer	March 2021	Service user changed to tāngata whaiora
05	Rachael Aitchison	August 2022	Addition of Puna Maatai and Puna Awhi Rua Addition of a set amount of expenditure for celebrations Change to current Te Whatu Ora Guideline format

Use of Purchasing Cards (P cards)

Contents

Use of Purchasing Cards (P cards)

1 Overview

1.1 Purpose

To manage and accurately account for expenditure on purchasing cards (P cards).

1.2 Staff group

This procedure applies to staff in the Mental Health Forensic service and ward 41.

1.3 Patient / client group

Forensic tāngata whaiora in Puna Poi Poi, Puna Taunaki, Puna Whiti, Puna Maatai, Puna Awhi-Rua and adult tāngata whaiora in Ward 41.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

Dockets	GST invoice itemising purchase
Transaction receipt	Shows the record of the bank transaction
Expenditure	The amount of money spent

2 Clinical management

2.1 Roles and responsibilities

All Staff

All staff using purchasing cards (P cards) must comply with this procedure

Managers

Monitor appropriate use of purchasing cards (P cards).

2.2 Competency required

All staff and tāngata whaiora are able to access purchasing cards (P cards) and utilise appropriately providing the necessary details and documents for accurate record keeping.

2.3 Equipment

- Purchasing cards (P cards)
- Purchasing card (P card) record book
- Purchasing card (P card) agreement

2.4 Guideline

1. To ensure that the person utilising purchasing cards (P cards) are familiar with the process and aware of amounts available, limits, pin numbers and items which can and items that are unable to be purchased with purchasing cards (P cards):

   All staff and tāngata whaiora must read and sign the purchasing card (P card) agreement and be familiar with the Te Whatu Ora Waikato Purchasing Card policy (Ref 0440).

2. When accessing purchasing cards (P cards) they must be signed out in the record book recording the time the card was removed, the name of the card user and card number before the card is removed from the area. This is done to ensure that all cards and expenditure can be accounted for at all times.

3. When a transaction is completed both the docket and transaction receipt must be retained and returned along with the purchasing card (P card). This is to assist with accurate accounting of expenditure and correct cost coding.

4. On returning the purchasing card (P card) complete the purchasing card (P card) record book stating time of return of the card, retailer, purpose of the transaction and the amount. This is to allow a readily available view of amounts utilised on cards so as not to exceed limits.

5. Receipts must be placed in the wallet provided and both the cards and book returned to the locked cabinet, to ensure safety of cards and receipts.

6. Nominated staff members to process receipts and approve purchases via internet banking. This will assist with accurately accounting for expenditure and correct cost coding and ensure that purchasing card (P card) limits are not exceeded. Also completed to meet audit and accounts payable requirements.

   A set amount approved by the Operations Manager for celebration is to be applied across the Forensic service. Where items are purchased for tāngata whaiora as part of a celebration – (Christmas and Birthday) a consistent monetary amount shall apply across all areas and be reviewed annually. In 2022 the approved amount should be up to $50 for the purposes of activity in relation to this event (birthday) and $80 (Christmas) for long term tāngata whaiora only.

3 Audit

3.1 Indicators

- All purchasing card (P card) users must cooperate with any audit undertaken externally or internally on purchasing card (P card) use.
- A clear audit trail of documentation will need to be maintained.

4 Evidence base

4.1 Associated Te Whatu Ora Waikato Documents

Purchasing Card policy (Ref. 0440)

Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions Acute Adult and Forensic Mental Health clinical staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Kylie Balzer	18 May 2020	Updated into current DHB guideline template Flow chart incorporated Inclusion of safety garment checklist on CWS
03	Kylie Balzer	June 2023	Updated to current Te Whatu Ora Waikato Guideline template Updates to purpose, exceptions / contraindications, flow chart, and after care.

Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service

Contents

Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service

1 Overview

1.1 Purpose

To provide the process and safety requirements for the use of safety garments for tāngata whaiora at risk of harming themselves with their clothing.

1.2 Staff group

Inpatient acute adult and forensic mental health and addictions service.

1.3 Patient / client group

Tāngata whaiora at risk of harming themselves or others with their clothing e.g. making a noose to hang themselves or to strangle others.

1.4 Exceptions / contraindications

The use of safety garments is contraindicated as a form of restraint, or for the management of behaviours related to clothing that could be managed in a less restrictive way.

1.5 Definitions and acronyms

Safety garment	A reinforced item of clothing that is tear resistant. It does not reduce movement or limit the tāngata whaiora ability to move freely. It must only be used as a last resort after less restrictive interventions have been implemented and have been unsuccessful.

2 Clinical management

2.1 Roles and responsibilities

Nursing Staff
Registered nurses who have achieved competency for safety gown use are able to make the decision for a tāngata whaiora to be placed in a safety gown. All nursing staff have a responsibility to ensure that the tāngata whaiora is cared for within a safe and respectful environment.

Managers
CNMs / ACNMs have responsibility for monitoring the appropriate use of safety gowns and escalation of their use to the Clinical Director, and if occurs after hours to the Charge Nurse Manager (CNM) of the ward via email.

2.2 Competency required

A registered nurse who has met the requirements of tier 3 of the mental health and addictions clinical practice skills checklist is able to make decisions about the use of a safety garment.

2.3 Equipment

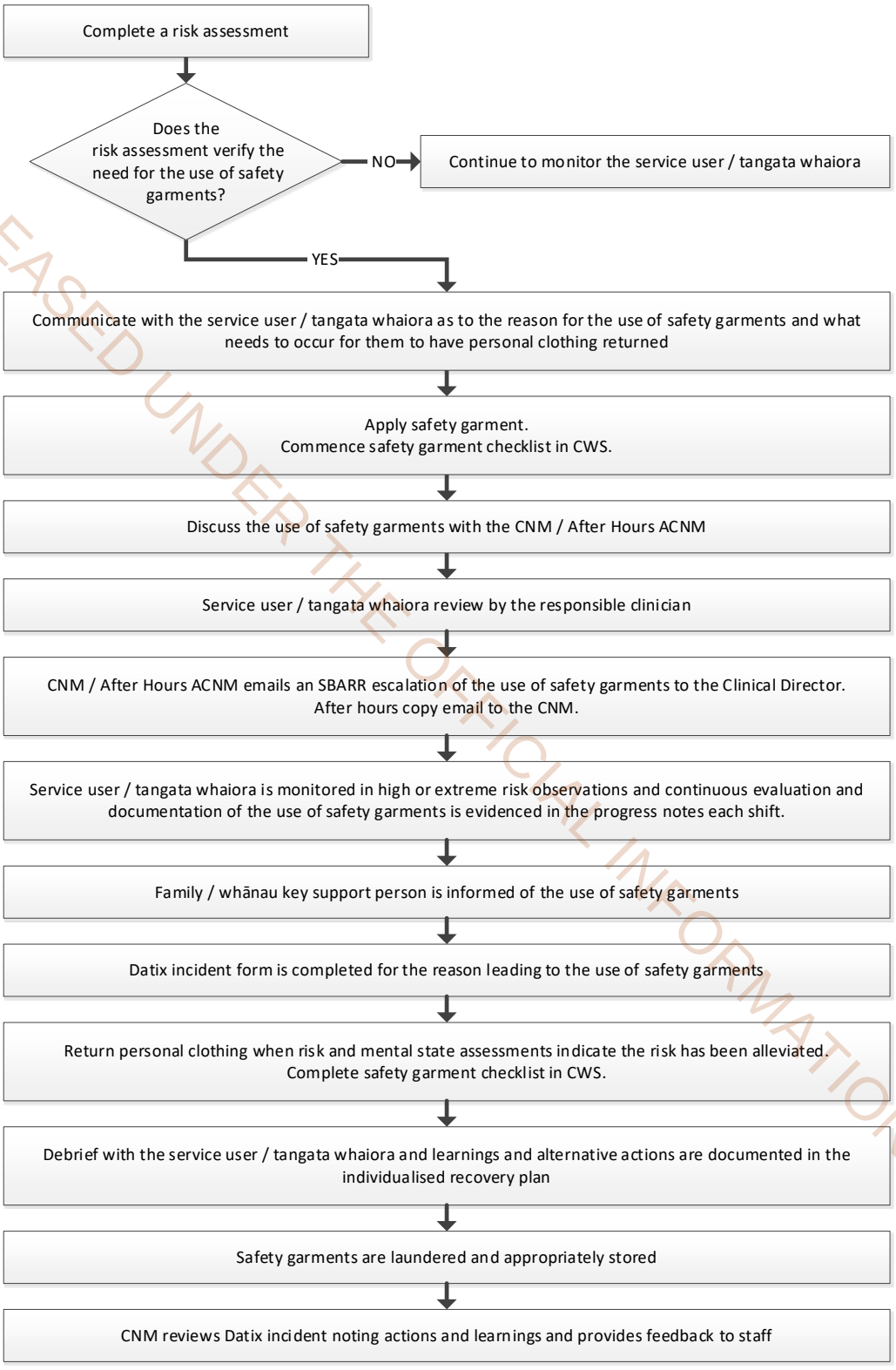
- Safety gown or safety shorts and tunic that meet the health and safety clothing compliance standards as approved for use within the service
- DATIX incident system
- Safety garment checklist in the clinical workstation
- SOAP progress note in clinical workstation
- Risk assessment and pattern analysis in clinical workstation

2.4 Guideline

Please follow the flow chart on page 5 of this guideline

Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service

Use of Safety Garments in the Inpatient Mental Health & Addictions Service



2.5 After care

Ensure that the following documentation provides information as to the use of a safety garment:

- Assessment and rationale for use is clearly outlined in the progress note, including all escalation / communication processes – CNM or after hours ACNM, responsible clinician (R.C.), Clinical Director and whānau.
- Monitoring of use
- DATIX incident form was completed for the reason leading to the use of the safety garment. Include the incident number in the progress note and on the safety garment checklist.
- Risk assessment and pattern analysis – the garments use is evident in the 'consequence of event' or 'protective factors' section
- Individuals recovery plan
- Safety garment checklist has been completed

Ensure documentation includes comments from the tāngata whaiora response to the use of a safety garment.

3 Patient information

The tāngata whaiora must be informed of the safety concerns as to why a safety garment is being used and continuously provided with updates to ensure that they are able to have their clothing returned at the earliest opportunity.

4 Audit

4.1 Indicators

- Safety garments are used in accordance with this guideline.

4.2 Tools

- DATIX incident report
- Safety garment checklist in clinical workstation (CWS)

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Levels of Observation Across All Mental Health and Addictions Inpatient Services procedure (5238)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)

- Incident Management policy (0104)
- Clinical Records Management policy (0182)
- SBARR Communication Tool guideline (5038)

5.2 External Standards

- Health and Disability Services Standards NZS8134:2021

Seclusion

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager Inpatients
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
05	Areann Libline	14 August 2017	The 8 hour SMO or delegate review involves a face to face assessment and a review of the current medication. Communication via email to the clinical director, service director and inpatient operations manager when a tāngata whaiora has been in seclusion for a period of 24 hours in a calendar month. This action is undertaken by the clinical nurse manager during working hours or the associate charge nurse manager Bureau, after hours. Communication via email or phone message to the district inspector when a tāngata whaiora has been in seclusion for a period of 48 hours in a calendar month. This action is undertaken by the registered nurse responsible for the tāngata whaiora care at that time. Addition of entry and exit of the seclusion room. Explicit reference to using a separate restraint event notification form if utilising personal restraint in the process of transferring to seclusion.
06	Areann Libline	3 August 2020	The inclusion of the RN clinical practice skills checklist (tier 3) for competency to make decisions relating to seclusion, the provision of care during and the ending of restraint / seclusion The inclusion of the use of high care lounges in the forensic inpatient service – (previously Doc ID 0538) The inclusion of set 8 hourly seclusion reviews by responsible clinician or delegate (0800, 1600 and 2400 hours) and the support by the ACNM Bureau to facilitate this.

Seclusion

Contents

Seclusion

1. Overview

1.1 Purpose

The purpose of this procedure is to:

- Clarify the roles and responsibilities of staff and the requirements for initiating, monitoring, reviewing and terminating the use of seclusion
- Maintain the safety of tāngata whaiora and others
- Ensure that practice implemented is guided by national standards and New Zealand legislation inclusive of the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Ensure that practice implemented is guided by the Waikato DHB Restraint Policy

1.2 Scope

This procedure is applicable to all Waikato DHB Mental Health and Addictions staff involved in the process of seclusion at any point

This procedure outlines the use of seclusion and does not cover environmental restraint for example, a locked ward.

1.3 Patient / client group

Tāngata whaiora under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Criminal Procedure Mentally Impaired Persons Act 2003 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 who meet the parameters for the use of seclusion.

1.4 Exceptions / contraindications

Seclusion can only be used for tāngata whaiora under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In the event of an emergency if seclusion is required for a tāngata whaiora who is not under the Mental Health Act, a registered nurse must make an application for assessment under Section 111 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

1.5 Definitions

Restraint:

The use of any intervention by a service provider that limits a tāngata whaiora normal freedom of movement (NZS 8134:0: 2008, Health and Disability Services (General) Standards, p.30)

Seclusion:

Where a tāngata whaiora user is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit (NZS 8134.0:2008, Health and Disability Services (General) Standards, p.30). Tāngata whaiora can only be subject to the use of seclusion when there is a continued risk to the safety of the tāngata whaiora or others.

Responsible Clinician:

The responsible clinician is the clinician in charge of treatment for a patient. After hours this role is usually delegated to the duty psychiatrist (Senior Medical Officer), or senior registrar approved by the Director of Area Mental Health Services (DAMHS).

Tier 3 Registered Nurse – competent in the use of seclusion

A registered nurse who has demonstrated tier 3 competency in the use of seclusion and has been signed off by the CNM / ACNM working in the area where seclusion is utilised.

Care Manager:

Responsible person for a tāngata whaiora under the ID (CC&R) Act 2003

Taonga
Refers to a treasure or something prized for example an item of cultural significance.

2. Clinical Management

2.1 Competency required

The Director of Area Mental Health Services must ensure seclusion rooms are fit for purpose and has an oversight of the quality systems monitoring for the use of seclusion within the service.

The use of seclusion can only be authorised or initiated by the following registered health professionals / or a care manager who may or may not be a health professional (registered or otherwise) appointed pursuant to Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:

- The responsible clinician or delegate, for tāngata whaiora legally subject to the Mental Health Compulsory Assessment and Treatment Act 1992
- The care manager for care recipients legally subject to the Intellectual Disability (Compulsory Care and Rehabilitation) ACT 2003 Section 60 (2).

All staff initiating seclusion must be competent in the process of restraint as per the Mental Health and Addictions restraint procedures (1865)

A tier 3 registered nurse, competent in the use of seclusion, is responsible for the seclusion environment and makes decisions in relation to the use of seclusion. They must be involved in the initiation, daily care of the secluded tāngata whaiora and ending of any episode of seclusion.

2.2 Equipment

The seclusion room must be a room designated for that purpose by the Director of Area Mental Health Services (DAMHS) and meet the requirements as set out in the Health and Disability services (Restraint Minimisation and Safe Practice) Standards – Seclusion NZS 8134.2.3:2008.

Appropriate mattress, pillow and blanket/s for the identified tāngata whaiora

Documentation:

Electronic seclusion authorisation form

Restraint Event Notification - electronic

Risk tools - electronic

Seclusion record form (monitoring) (A1029MHF)

Electronic seclusion evaluation form

DATIX incident reporting system

Electronic Clinical Work Station

Past seclusion debrief information is noted in the tangata whaiora recovery plan

Tāngata whaiora / Multidisciplinary Team Treatment Plan / Recovery Plan Adult Deterioration Detection System ADDS

Fluid Balance Chart

2.3 Procedure

Pre-seclusion

Recovery Plans and Advance Directives will outline the tāngata whaiora wishes in respect to the management of early warning signs and triggers of escalation.

Risk tools for a tāngata whaiora are to be updated as part of the dynamic risk management process.

When supporting distressed Infants, Children and / or Adolescents, it is preferred that a ratio of 2:1 be maintained to support the tāngata whaiora. Only under extreme violent conditions where de-escalation techniques have proved ineffective would consideration be made to use seclusion.

Medication plays a vital role in minimising distress and agitation and can reduce the likelihood of seclusion.

The use of high care secure lounges

The high care lounge (HCL) areas in Puna Maatai and Puna Awhi-rua are used for de-escalation or seclusion. This provides a safe environment to attempt and / or continue de-escalation of an individual whilst protecting their dignity and their right to privacy. If the HCL is to be utilised as a seclusion room, the tier 3 registered nurse competent in the use of seclusion is to initiate and monitor the seclusion episode in accordance with this seclusion procedure.

Any high care use involves the following

- Informing the CNM / ACNM after hour's coordinator of the intention to use high care so all staff are aware of the situation and ongoing safety requirements.
- Ensuring a three person team (in accordance with the personal restraint procedure) is present to ensure safety of the tangata whaiora and staff are not compromised.
- Consideration is given to nursing the tāngata whaiora with an open door or to initiate seclusion.

If high care is utilised to provide an environment to self-manage de-escalation, a sign is placed on the door indicating that the HCL is in use and the neighbouring ward is notified of the same. The tāngata whaiora utilising this area is to be

- Advised that they are able to exit at any time
- Reviewed by the team at 30 minute intervals and if they choose to, exit before this, a review of the service users / tāngata whaiora mental state, presentation and risk must be completed and documented.
- At a minimum, on significant risk observations.

Initiation of seclusion

Seclusion is a restrictive intervention that should only be utilised to prevent imminent violent behaviour compromising safety. In order to maintain safety, the minimum of a three person team, trained in the use of SPEC techniques need to be available.

In the absence of the medical team to assist in decision making, the decision to use seclusion can be made by a tier 3 registered nurse competent in the use of seclusion who has considered the following:

- All appropriate and available interventions have been utilised prior to the initiation of seclusion e.g. de-escalation strategies, negotiation, anger management, medication management, diversional activities, presence of whānau
- Staff have made a clinical assessment and taken into account actual clinical indicators that there is imminent risk to the tāngata whaiora or others
- Seclusion should not be used as punishment, used due to stress within the environment, used due to resource issues, used as a behavioural intervention or used for managing self-harm or risk of suicide.

- Acknowledgement of the potential for traumatisation / re-traumatisation in response to the use of seclusion
- Respecting the tāngata whaiora preferences and individual needs inclusive of advance directives

When moving a tāngata whaiora to the seclusion room continued dialogue, and calming techniques to minimise further escalation must be utilised. The tāngata whaiora should be moved in a planned manner, utilising restraint only if necessary in accordance with the Mental Health and Addictions restraint procedure/s (1865). If the tāngata whaiora is able to be de-escalated safely, without the use of seclusion, use this opportunity to discuss and document what worked in the tāngata whaiora recovery plan.

An assessment of risk must be made relating to items of clothing the person may be wearing at the time of seclusion. Any removal of items must be clearly validated based on a clinical risk assessment, communicated to the tāngata whaiora as to why, and documented in the clinical file. If using safety garments, only a Tier 3 registered nurse, competent in the use of safety garments can apply them, strictly following the guideline, completing the checklist in CWS, documenting, incident reporting (Datix) and escalating their use to those listed in the Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service (Doc ID 5788).

At the time of initiation of the seclusion episode the tāngata whaiora must receive an explanation as to why they are being placed in seclusion and what needs to occur for the seclusion episode to end. Every effort should also be made to provide the tāngata whaiora with information on what to expect within the seclusion room and how their basic needs can be met.

The tāngata whaiora must be informed of their rights, including the right to advocacy. The self-respect, dignity, gender needs and privacy of the tāngata whaiora is to be respected throughout the process.

The decision to use seclusion must be discussed with the tāngata whaiora whānau as soon as practicable i.e. during normal waking hours unless contraindicated.

Commence the Restraint Event Notification electronic form in CWS. If personal restraint was utilised to initiate the seclusion episode, a separate Restraint Event Notification electronic form requires completion.

Support may be accessed from the recovery advisor via email.

Complete a DATIX incident report outlining the preceding events resulting in the need for a seclusion episode.

Authorisation

If the Responsible Clinician (RC) or delegate has not been involved in the process of initiating seclusion they must be informed of the seclusion episode as soon as possible and have authorised continuing seclusion within 2 hours of its initiation using the electronic seclusion authorisation form. A face to face meeting must occur as soon as practicable and a clinical entry made in CWS that includes the review and plan to minimise the use of seclusion.

The tāngata whaiora care manager (or delegate) based on the Intellectual Disability (Compulsory Care and Rehabilitation Act) must be notified **immediately** of the decision to use seclusion. The delegate after hours is the night registrar.

A delegate must inform the RC as soon as practicable of the seclusion episode through handover processes.

The RC or delegate holds an ongoing responsibility for the authorisation or otherwise for the seclusion episode throughout the seclusion episode.

Seclusion is a restrictive practice and must be deemed a priority for review of the treatment approach by the RC or delegate at the very minimum of each shift.

Monitoring

A staff member as delegated by the responsible clinician or a registered nurse provides oversight of the seclusion episode to monitor the tāngata whaiora throughout the seclusion episode. The registered nurse holds responsibility for the overall monitoring process, and should enter the seclusion room at a minimum of 2 hourly intervals. Between the hours of midnight to 0600 hours, if considered more beneficial for the tāngata whaiora to sleep and not be woken, the room can be entered quietly to check their physical health status. Any room not entered at the 2 hourly assessment point must have a detailed rationale recorded in the clinical notes as to why it did not occur. The normal process of assessment will take place at any other time and will include:

- Mental state assessment
- Clinical risk assessment
- Physical state assessment
- Consideration of spiritual / social needs

There will be a delegated staff member present outside the seclusion room for the purpose of engagement and attending to the service users' needs for the duration of the episode. As per the seclusion record form, clinical documentation will be made at a minimum of every 10 minutes (Seclusion record form A1029MHF). The minimum observations within the 10 minute interval include and are not limited to general condition, colour (e.g. cyanosis, pallor), breathing, position, activity and behaviour.

Documentation of a seclusion episode is within the Seclusion Progress note section of the Clinical Workstation (CWS) and will include all of the assessments undertaken during the seclusion episode.

The process for entry to the seclusion room / high care seclusion room will include:

- The minimum of three SPEC trained staff and a registered nurse for the administration of medications / staff member for the transfer of equipment into the room
- All equipment required will be assembled outside the seclusion room and an assessment for safety and cooperation will be made prior to entry to the room
- Clear plan is agreed by staff prior to entry to the room: inclusive of communication, actions, responsibilities
- Communication with the tāngata whaiora is established
- When entering the room inform the tāngata whaiora of entry and why and request that they sit / lie on the mattress

When the seclusion room / high care seclusion room is entered and exited:

- Staff to maintain visual contact on the tāngata whaiora at all times
- Maintain awareness of the team roles as outlined in SPEC if the situation escalates
- communicate to the tāngata whaiora and ensure understanding of what you require e.g. monitoring of vital signs
- If the tāngata whaiora declines care requirements or becomes agitated / aggressive NO equipment is to be taken into the room. The team must assess safety and / or exit the room at any point of resistance / agitation / aggression
- A safe exit of the seclusion room may require restraint as per SPEC training and the Personal Restraint Procedure
- If the tāngata whaiora remains amenable with care requirements then equipment can be brought into the room preferably by the fourth staff member
- Ensure ALL equipment is removed from the room prior to staff exit of the room
- Full documentation of entry and actions taken must be completed in the Clinical Workstation (CWS)

Each entry of the seclusion room is an opportunity to assess the readiness of the tāngata whaiora for reintegration.

Handover of care between shifts is in accordance with the Clinical Handover, Mental Health inpatient wards procedure (0451).

8 hourly assessments of seclusion and care

The responsible clinician or delegate completes an 8 hourly, face to face assessment of all tāngata whaiora in seclusion. This assessment includes a review of the current medication prescribed. This assessment is to be documented on the clinical workstation as a clinical note.

To ensure 8 hourly reviews are better co-ordinated, the reviews will be conducted at the following times:

- 0800 hours
- 1600 hours
- 2400 hours

This provides the treating team with two opportunities to review during week days and on weekends and after hours allows the duty doctor to plan based on the routine times for

seclusion reviews. The ACNM Bureau will monitor the seclusion episodes occurring in both the adult and forensic inpatient settings and will support the review process.

If a tāngata whaiora is placed in seclusion and the seclusion is authorised before or after the stated review times, the next review is conducted at the next review time and thus falls into the 8 hourly review timeframes.

Following the 8 hourly assessment/s the RC or delegate communicates a decision as to the continuation or otherwise of seclusion to the tier 3 registered nurse competent in the use of seclusion who has oversight of the seclusion episode of care.

24 hourly reviews

When a tāngata whaiora has been in seclusion for a period of 24 hours whether continuously or in a calendar month the following needs to occur:

- Case management discussion with the treating team inclusive of RC by a CNM / ACNM / CNS. If the 24 hour period is reached during the night, the review will be conducted as soon as practicable the following day. If the 24 hour period is reached over a weekend, then a review by the on duty SMO and ACNM Bureau is undertaken.

A daily review by the RC / SMO is undertaken for each tāngata whaiora in seclusion, inclusive of weekends.

Outcomes of the case review are fully documented in the seclusion progress note by the CNM / ACNM / CNS.

The tāngata whaiora whānau will be informed of the case review outcome(s).

Notification of the outcome(s) of the 24 hourly review is made to the Director of Clinical Services / Director of Area Mental Health Services (DAMHS).

When a tāngata whaiora has been in seclusion for a period of 24 hours within a calendar month the following needs to occur:

- Communication via email to the Clinical Director and inpatient Operations Manager
- Communication via email to the Director of the associated service

The above communication will be undertaken by the Charge Nurse Manager or delegate and after hours by the Associate Charge Nurse Manager Bureau.

When a tāngata whaiora has been in seclusion for a period of 48 hours within a calendar month the following needs to occur:

- Communication via email or telephone to the District Inspector

This communication will also be undertaken by the registered nurse responsible for the service user / tāngata whaiora care.

Nursing Care whilst in seclusion

Mental Health

Listen to the tāngata whaiora explanation of their needs and address these wherever possible. Provide explanations if needs are not able to be met.

Take and document nursing observations of mental state as component of observations.

Provide reality orientation, inclusive of orientation to time, place and event, whenever the seclusion room is entered, or upon request by the tāngata whaiora.

Provide appropriate and safe material to assist the tāngata whaiora to keep focused on reality, grounded and occupied e.g. Newspaper, magazines, radio, appropriate sensory modulation items.

Continually assess progress with the tāngata whaiora towards the goal of re-integration.

Physical Care

The physical status of the tāngata whaiora must be monitored on an ongoing basis inclusive of vital signs and other monitoring as clinically indicated.

The effectiveness and any side effects of any medication administered are to be monitored and documented.

All physical needs e.g. toileting; washing must be met as appropriate throughout the seclusion episode.

Assess the need to provide NRT products to assist the tāngata whaiora to avoid nicotine withdrawals, if they are secluded after admission or who are already using NRT as an inpatient.

Food and Fluids

The tāngata whaiora is provided with finger foods / soft foods utilising disposable plates and spoons when required for breakfast whilst in seclusion.

Fluids are to be offered regularly.

Monitoring of food and fluid intake is to be maintained and documented for all service users / tāngata whaiora in seclusion.

Cultural and Spiritual

Taonga are to be assessed as to the safety for the tāngata whaiora. If taonga are removed it must be kept safely and returned to the tāngata whaiora when assessed to be safe by clinical staff.

Whānau can visit a tāngata whaiora if they are able to be safely supported to a less restrictive environment outside of the seclusion room area. If this possible, then seclusion may not need to continue.

The tāngata whaiora will be able to access support of kaitakawaenga whilst in seclusion and during the process of re-integration during normal office hours.

Other support such as lawyer / district inspector should also be accessible to the tāngata whaiora in seclusion.

Support may be accessed from a recovery advisor role Monday to Friday during working hours.

Blessing of the seclusion room may be appropriate following a seclusion episode and staff may wish to facilitate this by contacting Te Puna Oranga during working hours or the after-hours chaplaincy service.

The tāngata whaiora is to be able to undertake religious observance with due regard to risk management.

Re-integration period

The movement of a tāngata whaiora out of a seclusion room into open areas must be pre-planned, occur safely, be evaluated and documented in the seclusion progress note in the clinical record. Resources to do this must be available for example, an appropriate space and safe staffing (three person team).

On re-integration out of seclusion the tāngata whaiora will be assessed and placed on a level of observation to reflect their level of risk. The level of observation will be regularly reviewed during the reintegration period.

Whānau should be informed that their whānau member is out of seclusion as soon as is practicably possible.

Ending seclusion

As soon as there is no longer an imminent risk to tāngata whaiora or others, seclusion **must** cease. The responsible clinician (or their delegate) or the registered nurse in discussion with a senior or Tier 3 registered nurse can end seclusion at any time based upon a current risk assessment.

Consultation with the tāngata whaiora responsible clinician / care manager (or delegate) should occur simultaneously where possible.

The electronic seclusion ending form and the seclusion evaluation form are completed when the tāngata whaiora has been out of seclusion for more than one hour.

Review the risk tool documentation and tāngata whaiora recovery plan at the end of a seclusion episode and include any relevant updates arising from the seclusion episode, including but not limited to early warning signs and triggers.

Complete the electronic Restraint Event Notification in CWS

Inform the whānau when seclusion has been terminated.io

Following the use of the seclusion room the area is to be cleaned by inpatient staff and if a sanitising clean is required this should be requested through ISS cleaners

2.4 Potential Complications

Extreme caution in the use of seclusion must be taken when a tāngata whaiora is intoxicated, actively suicidal, potential delirium, physically unwell, ingested unknown substances, unstable medical condition, pregnancy, where age is a vulnerability factor e.g. over 65 years of age, those under 18 years of age, fluctuating levels of consciousness or other neurological side effects, likelihood of respiratory suppression or other cardiovascular effects, possibility of escalation of anxiety, aggression or distress or a previous adverse outcome from the use of seclusion. Under these circumstances, a clear plan must be formulated with the Tier 3 RN and the medical team to ensure appropriate care is provided. This will be documented in the clinical file and be referred to and used by staff working in the Low Stimulus Area.

2.5 After Care

A debriefing process for the tāngata whaiora is completed post seclusion episode. This involves the ACNM or delegate discussing what could have helped to prevent the seclusion episode for example, the use of sensory equipment, whānau involvement, specific PRN medications that are known to have good effect. Any learning is included in the recovery plan and listed as acute care interventions.

Staff diffusion and debrief processes.

3. Patient Information

Waikato DHB Restraint pamphlet

Staff must tell the tāngata whaiora why they are in seclusion and what the goals are to be achieved to end the seclusion episode

4. Audit Indicators

4.1 Indicators

Total hours of seclusion

Number of seclusion episodes per month

Number of seclusion episodes (Māori)

Seclusion room audit completed at a minimum of six monthly

Seclusion episode debrief with interventions in the recovery plan

4.2 Tools

Enterprise reporting process

Seclusion room audit tool

Recovery plan

5. Evidence Base

5.1 Summary of Evidence, Review and Recommendations

The Seclusion procedures from the following District Health Boards were reviewed in the updating of the Waikato DHB procedure: Capital and Coast; Bay of Plenty; Whanganui Southern District, MidCentral Health, Auckland and West Coast.

5.2 References

The Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZ8134.2.3:2008. Wellington: MOH.

Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992, 2010. Wellington: MOH.

The Mental Health Compulsory Assessment & Treatment Act 1992 and 1999 amendments. Wellington: MOH.

The Criminal Procedure Mentally Impaired Persons Act 2003 Wellington: MOH.

The care manager for care recipients/consumer/care recipient legally subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 Section 60 (2). Wellington: MOH

5.3 Associated Documents

- Mental Health & Addictions Clinical Handover – Mental Health Inpatient Procedure (0451)
- Mental Health & Addictions Family Whānau Participation Policy (0896)
- Mental Health & Addictions Levels of Observation in Inpatient Services procedure (5238)
- Mental Health & Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others (5241)
- Mental Health & Addictions Sensory Modulation Procedure (3248)
- Mental Health & Addictions Personal Restraint in Mental Health and Addictions Inpatient Setting (1865)

- Mental Health and Addictions Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service Guideline (5788)

- Mental Health and Addictions Registered Nurse Clinical Practice Skills checklist (E1085HWF)

- Waikato DHB Clinical Records Policy (0182)
- Waikato DHB Incident Management Policy (0104)
- Waikato DHB Restraint Policy (2162)
- Waikato DHB Restraint – Wrist and Ankle (2158)

Visiting Adult Inpatient Mental Health Wards and OPR1

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions Service
Document Facilitator Name	Kylie Balzer
Document Facilitator Title	Operations Manager
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions service staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
2	Kylie Balzer	October 2023	Real time feedback removed as an audit indicator OPR1 included into this guideline Safety requirements added e.g. infection prevention and control, guidance in emergency situations

Visiting Adult Inpatient Mental Health Wards and OPR1

Contents

Visiting Adult Inpatient Mental Health Wards and OPR1

1 Overview

1.1 Purpose

It is important to a tāngata whaiora recovery that they continue to maintain contact with whānau and significant others (visitors) as their main support systems throughout their care, including during admission to an acute inpatient unit. Due to the nature of the inpatient environment, it may at times be necessary to place some restrictions on visiting. Our guidelines are for the safety and wellbeing of tāngata whaiora, visitors, and staff.

The Code of Health and Disabilities Services Consumer's Right Regulation 1996 states that tāngata whaiora:

Have one or more support persons of his / her choice present, except where safety may be compromised or another person's rights may be unreasonably infringed.

To adhere to this statement this guideline sets out to:

- Define the visiting hours for the adult inpatient mental health wards and OPR1
- Ensure that tāngata whaiora have reasonable access to a whānau / carer and visitors whilst in the inpatient unit
- Describe the out of hours visiting process

1.2 Staff group

This guideline applies to adult inpatient mental health wards and OPR1.

1.3 Patient / client group

Adult inpatient tāngata whaiora and OPR1.

1.4 Exceptions / contraindications

Nil

1.5 Definitions and acronyms

Key support person	The person or persons nominated by the tāngata whaiora to provide emotional and practical support (as the tāngata and key support person wishes) during their stay in the hospital or facility. A key support person will typically be a loved one, for example a spouse, partner, adult child, sibling, close friend, whānau member (although not limited to those definitions). The key support person may change at intervals in response to the tāngata whaiora wishes and availability of a specific person. Tāngata whaiora are not obliged to nominate a key support person. A key support person may also (although not necessarily) be the tāngata whaiora next of kin, the spokesperson or the Enduring Power of Attorney.
Next of kin	The person officially notified by the patient as their next of kin and logged on hospital records as such. The next of kin may (although not necessarily) be the key support person.

Visitors	All other people visiting the tāngata whaiora
ACNM	Associate Charge Nurse Manager

2 Clinical management

2.1 Roles and responsibilities

All Staff

- All staff in inpatient areas are responsible for implementing these guidelines.
- All staff visiting the inpatient unit must wear their Te Whatu Ora Waikato identification.

Managers

- The Charge Nurse Manager or their delegate has overall responsibility for ensuring that the guideline is followed with consideration for all tāngata whaiora, key support people and staff in the area.

2.2 Competency required

- Communication skills to discuss the guidelines with tāngata whaiora, visitors, whānau and key support people as required.
- Critical thinking and discretion when using the guideline, applying it to individual circumstances and communicating it to individual visitors.

2.3 Equipment

- Signage regarding visiting hours in the adult inpatient service and OPR1
- Signage advising of infection prevention and control requirements

2.4 Guideline

2.4.1 Arrival at reception / ward

- All visitors will report to the wards and press the ward door bell.
- All visitors to adult inpatient wards and OPR1 will be escorted onto the ward with staff
- Staff will provide guidance to visitors on any infection prevention and control or other safety requirements
- The shift lead is to be aware of visitors on the ward and guidance is to be provided in the event of an emergency situation.
- Visiting community mental health staff and contractors must display their Te Whatu Ora Waikato identification at all times.

2.4.2 Whānau / Key Support Person

We recognise and acknowledge the difference between key support people and general visitors and the role that each play in the care, recovery and treatment of tāngata whaiora.

A tāngata whaiora may wish to nominate a key whānau / caregiver who may be a partner, relative or friend.

We welcome key support people to visit from 8am to 8pm or longer at the discretion of the Charge Nurse (or their delegate). The decision will be made in the best clinical interest of the tāngata whaiora and other tāngata whaiora on the ward.

At the request of the tāngata whaiora (if capable) the key support person is welcome, but not obliged, to be present with the tāngata whaiora they support to:

- Participate in clinical conversations and whānau meetings
- Help with basic / essential care needs (in agreement with appropriate staff)
- Support the tāngata whaiora with decision making
- Support transition of care out of hospital

In a situation where a tāngata whaiora has elected to have more than one whānau member / caregiver, ward staff will discuss with the CNM or ACNM outside usual working hours as to the number of people who may be permitted in a ward at any one time.

When staff consider that it is in the tāngata whaiora and / or other tāngata whaiora best interests to limit the number of whānau / carer to one, the reasons for this decision will be explained to the tāngata whaiora, their whānau / caregiver and documented.

Ward staff will monitor the clinical state of the tāngata whaiora before, during and following visiting in order to maintain clinical safety and provide any debriefing required.

2.4.3 Visiting children

- The reception is to notify the ward prior to visitors with children entering the unit. Visiting children are to be closely supervised at all times by their whānau / carer and are not to be left unattended.
- Children must visit in designated areas and are not permitted inside the ward areas.
- Designated visiting areas for children are the interview rooms, admission suite, Level 3 meeting room and staff room.
- Visiting children remain the responsibility of the whānau / carer whilst in the adult inpatient unit and OPR1.

2.4.4 Food / Fluids

Whānau / carer are encouraged to bring in appropriate food / fluids for their friend / whānau.

Staff need to review these items for suitability (check for drugs / illegal or prohibited items), storage (requiring refrigeration), and appropriateness (e.g. lipid rich food in cases of metabolic syndrome, those on diabetic diet).

2.4.5 Visiting hours for the wards

Visiting hours for wards 34/35/41	Monday - Friday 1530 – 2000hrs Saturday – Sunday 1000 – 2000hrs Public Holidays 1000 – 2000hrs
Visiting hours for ward 36 and LSA	Monday – Friday 1530 – 1900hrs Saturday – Sunday 1000 – 1900hrs Public Holidays 1000 – 1900hrs

Visitors are limited to 2 persons at a time and may be restricted to ensure a safe environment at the discretion of the Charge Nurse Manager / delegate.

Visiting hours OPR1	11am to 1.30pm and 4 pm to 8pm daily

2.4.6 Out of hours

No whānau / caregiver is permitted to visit outside of the visiting hours except where approval has been given in advance by the Charge Nurse Manger of the ward or the ACNM outside usual working hours. This should be documented in the multidisciplinary team plan and clinical notes.

2.4.7 Visiting Hours for Ward 36 and LSA

Ward 36 and LSA is a specific high care area within the HRBC. There are potential risks for visitors within this environment and a potential for harmful items to be brought onto the unit, therefore specific care is required. Additional guidelines have been put in place to mitigate risk:

- A nominated visiting room both within the open side of ward 36 and LSA (interview room which has high visibility) is to be used for visiting. This is to be monitored by nursing staff at all times.
- Whānau and friends must **book time slots to visit ward 36**. These bookings are made via the ward directly.

- One to two visitors at a time per tāngata whaiora can visit, unless otherwise deemed safe by the Charge Nurse Manager of the ward or the ACNM outside usual working hours
- There is to be only one visiting group at a time on the ward unless there is an exception made by the Charge nurse Manager of the ward or the ACNM outside usual working hours
- Visitors are not permitted to take bags into ward 36 unless they are items for the tāngata whaiora which will be listed and possibly stored
- The Charge Nurse Manager of the ward or the ACNM outside usual working hours will agree on the approximate visiting time with the visitor, this will not exceed 30 minutes.
- Children are not permitted in ward 36. Alternative arrangements can be made to support a connection as required; this may include the use of technology.

2.4.8 Managing challenging incidents involving visitors

Ward staff have the right to:

- Refuse or limit access for clinical or safety reasons. These are to be explained to the visitor and clearly documented in the clinical work station
- Verbally question any person visiting the ward. This includes staff, legal practitioners and volunteers who are expected to provide identification and evidence of reason for visiting
- Check all items are brought in for safety and appropriateness
- Supervise visits if deemed necessary for example if there is reasonable grounds that the visitor may have brought in prohibited items
- Ask any person to leave if they feel their safety or the safety of others is at risk
- When necessary ban specific visitors including the use of trespass notices, and inform the policy if a crime may have been committed by a visitor

Unacceptable behaviours

- Visitors and whānau / carer must maintain an appropriate standard of behaviour whilst within the adult inpatient mental health wards and OPR1.
- Behaviours that are deemed unacceptable and are not to be tolerated include:
  - Verbal or physical assault on tāngata whaiora , staff or other visitors
  - Aggressive, threatening, disruptive or intimidating behaviour
  - Intoxication with legal or illegal substances
  - Supply of legal or illegal intoxicating substances
  - Supply of tobacco related products to inpatients
  - Theft or damage to property

- Breach of non-trespass order
- Sexual harassment or sexually inappropriate behaviour
- Smoking on site

3 Patient information

Information on visiting hours on the mental health and addictions section of the Te Whatu Ora Waikato internet site.

4 Audit

4.1 Indicators

- Tāngata whaiora / whānau / carer feedback on visiting
- Staff feedback on visiting

4.2 Tools

- Consumer feedback and complaints
- DATIX incident system monitoring

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Consumer Feedback and Complaints policy (0101)
- Incident Management policy (0104)
- Security policy (Ref. 0120)
- Visiting Patients at Waikato DHB Facilities guideline (Ref.0125)

5.2 External Standards

- Code of Health and Disabilities Service Consumer's Rights Regulation 1996
- Ngā Paerewa Health and disability services standard 8134:2021

Whānau Inclusive Practice

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions Service
Document Facilitator Name	Lynette Eade
Document Facilitator Title	Professional Lead Social Work
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Document Owner Title	Clinical Services Director
Target Audience	Mental Health and Addictions staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Lynette Eade and Wheeti Mapai	March 2020	Update to audit indicators

Whānau Inclusive Practice

Contents

Whānau Inclusive Practice

1 Overview

1.1 Purpose

The purpose of this guideline is to guide staff within the Mental Health and Addictions Service on engagement with whānau throughout the provision of care within the Integrated Care Pathway. The Mental Health and Addictions Integrated Care Pathway (ICP) places whānau involvement / support as integral to the recovery approach (Mental Health and Addictions Integrated Care Pathway policy). The inclusion of whānau aligns to strategic imperative 3.2 'People Centred Services' of the Waikato DHB strategy.

One of the core elements of whānau inclusive practice is the engagement and experience of whānau throughout 'their loved ones' recovery journey. Tāngata whaiora are not unwell in isolation of their whānau, and so an approach that takes into consideration their needs as well as those of the tāngata whaiora, ensures a holistic psychosocial approach to delivery of care. Engagement of whānau should be considered a critical success factor to ongoing support and successful recovery long after the intervention provided by secondary mental health services has ended.

This guideline also aims to incorporate the holistic Māori Model of care, Te Whare Tapa Whā as created by Dr Mason Durie. The core elements of these models include: the health and wellness of the tāngata whaiora through the inclusion of whānau and the use of whakawhanaungatanga / connecting through genealogy / whakapapa and the chosen networks of people. It is also important to recognise Te Tiriti O Waitangi principles of Partnership, Participation and Protection to guide best practice of tāngata whaiora that identify as Māori.

Whānau inclusion assists with recovery by:

- Developing a positive identity, improving social inclusion, helping develop social roles, assists in advocacy, promotes wellbeing, provides support (Slade, 2009)
- Fewer relapses and hospitalisation
- Increased tāngata whaiora participation in vocational rehabilitation programs
- Improving whānau wellbeing
- Greater whānau knowledge of serious mental illness
- Fewer feelings of stress and isolation
- Reduced wellness/wellbeing and use of medical care of whānau.

When working with whānau it is important to acknowledge the potential impact of mental illness on whānau including:

- Worry and concern
- Distress due to whānau members wellbeing
- The emotional impact of care giving
- Relationship stress with unwell whānau member

- Tension in carers life
- Depression and anxiety
- Frustration over apathy and lack of motivation

1.2 Scope

This guideline applies to all staff and areas within the Mental Health and Addictions service.

1.3 Patient / client group

This guideline is applicable to tāngata whaiora throughout the Mental Health and Addictions service.

1.4 Exceptions / contraindications

Nil exceptions / contraindications

1.5 Definitions

Other carer	Other carers, who may be whānau or close friends, have a major role in supporting people with mental health difficulties to recover or cope as best they can with the condition.
Participation	Acknowledging the strengths within whānau and working together with community support services rather than treating tāngata whaiora in isolation
Partnership	Encouraging and supporting whānau to participate in the recovery of tāngata whaiora and ensuring whānau (including the children) of tāngata whaiora have access to information, education and support
Protection	Ensuring that health services and delivery are appropriate, acceptable and respectful of culture, values and beliefs to tāngata whaiora and their whānau.
Whānau	The tāngata whaiora, whānau, extended family, partner, siblings, friends or other people that the tāngata whaiora has nominated as a carer (see other carer)

2 Clinical Management

2.1 Roles and Responsibilities

Clinicians

All clinicians are to consider and engage the whānau as appropriate at all points of contact in the tāngata whaiora care journey to ensure that the tāngata whaiora's whānau are included in the recovery pathway when consent has been given.

Managers

The managers in coordination with the family facilitator are to review any whānau feedback. The managers are to initiate quality improvement initiatives.

2.2 Competency required

Staff need to complete the whānau inclusive practice workshop within 6 months of commencement with the mental health and addictions service.

2.3 Equipment

Clinical record

Consent documentation

2.4 Guideline

1. Action: Triage / Crisis Assessment

Gain consent of the tāngata whaiora for the involvement of whānau as designated by tāngata whaiora in their treatment and recovery process.

Our role should be to support whānau and understand the impact of illness on both whānau and the tāngata whaiora.

If a tāngata whaiora does not wish whānau to be involved in their treatment then staff need to fully explain to the tāngata whaiora the benefits of whānau involvement and support. Clearly document in the tāngata whaiora clinical file and review at regular intervals the members of whānau the tāngata whaiora consents to participate in their recovery plan. Clinicians to clearly inform whānau of the consent process and refer them to appropriate whānau facilitator and kaitakawaenga service for support until the tāngata whaiora give consent. Any information received from the whānau to be acknowledged and recorded.

Consider the part illness may play on tāngata whaiora attitudes towards whānau members.

If whānau are engaged in the referral process, then they should be provided with information about community support agencies that can help them whilst their whānau member is unwell. These community agencies include; Supporting Families Waikato, People Relying on People, Te Runanga o Kirikiriroa, Hauora Waikato or other NGO's available in their area.

Information gathering will vary according to the needs of the whānau you are working with. The aim is to understand the current circumstances for the whānau and the tāngata whaiora

The whānau have experience and intimate knowledge of the person with mental un-wellness.

If the tāngata whaiora is a parent or is around children or vulnerable adults an important part of our responsibility includes making an assessment of the impact of current / recent mental state on the person's ability to prioritise needs of dependants.

The following questions should be asked as part of this assessment process.

- Does the tāngata whaiora have a child or children in their care and if so what are their ages?
- Are there any safety issues for children or other whānau?
- If so, are there any contingency plans (i.e. Advanced Directive) in place for when the tāngata whaiora is in crisis?
- Is the tāngata whaiora concerned about their children in any way?
- What current support do they have available for their children?
- Are they aware of community supports available for children / whānau?
- Where are the children now?
- Have Oranga Tamariki (OT) had any recent or past involvement with tāngata whaiora's children? Are Oranga Tamariki currently involved?
- Are there any other adults living in the household? If yes, how many and what is their relationship to the tāngata whaiora?
- Are there any vulnerable /dependant adults living in the household? What supports are they in receipt of?

In the triage assessment phase prioritise assessment when there is evidence of potential risk to children, or when risk is not yet known. Assess the safety of the children as follows for acute situations:

Interaction, child responsibility, mental / emotional / physical / practical needs, environment, gathering and analysing information about the nature of the relationship between parent and child, the parent's ability to manage stress.

Assess the adequacy and effectiveness of the parent's current treatment and the likelihood they are able to provide 'good enough' parenting over the course of childhood.

If there are any concerns regarding the welfare or wellbeing of children under the age of 16 years, contact Child Protection Advisory Support Service (CPASS) to discuss concerns / notification. (Waikato DHB Violence Intervention Programme – Child Protection policy)

Clinicians have a 'duty of care' to liaise with Oranga Tamariki if any children involved under 16 years of age are known to Oranga Tamariki to ensure partnership and interagency

collaboration. Follow the requirements of the Local Partnership and Communication Protocol between Oranga Tamariki and the Mental Health and Addictions Service.

If during the triage assessment you not identify any safety concerns then:

- If child is 'not known' to Oranga Tamariki, clinician to identify any unmet needs of child (preventative management) by supporting the tāngata whaiora with 'practical supports' (to avoid crisis / when in crisis) via NGO and DHB package of care funding.
- Assessment and consideration of the level of distress and coping strategies of whānau members
- Consider options available for respite
- Provide advice on how to handle situations when the tāngata whaiora is avoiding or resisting support
- Provide information about mental illness and services available to carers through educational / support avenues and managing a crisis situation

If the triage screening assessment identifies safety concerns then: refer for urgent crisis assessment, whenever possible in home environment. A home visit will provide information and support engagement with the whānau.

2. Action: Comprehensive Assessment

In the Comprehensive Assessment assess the following:

- The need for support regarding daily living and current tasks the tāngata whaiora considers difficult
- The tangible requirements of the tāngata whaiora for caring for whānau
- Financial implications on the whānau and its effects
- Disruption of daily life and effects on the household routine e.g. practical support for children – meal preparation, personal care, and transport to school
- The historical perspective of current issues
- Achievement of developmental milestones for children
- Current involvement of whānau members and other support agencies
- Any safety issues and contingency plans
- The ability of the parent to provide for the basic needs of children / dependants now and into the future
- Whether parent can communicate with child about the mental illness (shared whānau understanding)
- Child knows that they are not to blame / are not responsible
- Child is able to build good social contacts in their community
- Child has access to a supportive adult
- The provision of educational resources

- Assessment for whānau violence as per the requirements of the Waikato DHB Family violence intervention – Partner abuse policy (2202). Where care and protection issues are raised the information is to be provided by the clinician holding the concerns and is not to be provided second hand.
- Engagement with children and the impact of un-wellness on whānau time and quality of life
- Understanding and awareness of children and whānau mental un-wellness and its impact

Consider referral to Whānau Facilitator inpatient or community NGO support for advocacy and support.

Referral to Kaitakawaenga / cultural facilitator for cultural input as appropriate within the service.

Utilise interpreters as appropriate Waikato DHB Interpreters policy

3. Action: Recovery planning

During recovery planning ensure the following are completed and documented:

- Regularly review and seek permission for whānau engagement from tāngata whaiora
- Negotiate what information can be shared with whānau, if they are unable to consent when unwell
- Monitoring for symptoms of early warning signs
- Signpost whānau as appropriate for support by external agencies
- Ensure cultural input is being provided as per assessment requirements
- Ensure contingency planning for children / dependants and plan respite as appropriate
- Consider wrap around approaches to manage complex cases
- Tāngata whaiora are not unwell in isolation

4. Action: The Bio Psychosocial Intervention phase

- Ensure whānau are central to the recovery review meetings and contribute to the multidisciplinary team discussion
- Discussion with whānau the role they can play in treatment and recovery planning, relapse prevention, risk management, provision of information to support assessment, medication oversight and supporting follow up of the tāngata whaiora
- Provision of support as required for the whānau i.e. education, information to ensure whānau are well informed and aware of the community support
- Ensure early notification to whānau of meetings to allow whānau to attend
- Referral and liaison with appropriate community support systems for whānau

5. Action: Transfer of Care

Whānau play a major role in post transfer of care / community and inpatient through regular contact with tāngata whaiora.

Discuss ongoing support for whānau, relapse plan, seek advice and support form multidisciplinary team by sharing 'risk' and concerns.

Social Workers across the HRBC complete a whānau form with whānau and request feedback on inpatient experience prior to discharge / transition of care to community.

Where applicable spend time with whānau to discuss and provide information on monitoring of symptoms, identifying early warning signs, risk management, medication oversight, ongoing rehabilitation, socialisation, regular telephone / face to face contacts, accommodation, joint activities, and ensure advance directives are in place.

Encourage whānau supporting their 'loved ones' to re-engage with treatment or inform staff as soon as possible when there are early warning signs of decompensation in mental health wellbeing.

Provide tāngata whaiora with resources for children and vulnerable adults e.g. respite, parenting, family works, link families with agencies that work with children / parents.

Age appropriate information for children around parental mental un-wellness – early warning signs, symptoms and who to contact for help/support.

Referral to carer support prior to transfer of care / discharge.

If the tāngata whaiora is under the Mental Health Act (please refer to guideline regarding sharing information on the Waikato DHB intranet).

3 Patient information

Provide whānau with the Mental Health and Addictions service 'Information for whānau / friends' information pack and document that this has been provided in the clinical record.

4 Audit

4.1 Indicators

- Adherence to this procedure will be evidenced through audit of clinical files, management of complaints involving whānau engagement. Monitoring of KPI's.
- Whānau (or support carer) who the tāngata whaiora agrees could be involved in their recovery care are identified at the initial point of service contact.

4.2 Tools

- Real Time feedback
- Service wide KPI monitoring
- Clinical audit of whānau engagement
    - o All monitoring will include information related to Māori equity

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

- How Families Fit On The Path To Recovery www.mifa.org.au/sites/.../MIFNQ_HowFamiliesFitPathwayRecovery_P.ppt by Glenda Blackwell Waikato DHB Strategy 2016
- Marina Barnard, 27 April 2005.Ministry of Health. (2000*). Involving Families: Guidance notes.* Wellington: Ministry of Health
- Tikanga best Practice Guideline Waikato District Health Board
- Te Rau Hinengaro: The New Zealand Mental Health Survey Citation: Oakley Browne, M. A., Wells, J. E., & Scotts, K. M. (Eds). (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
- Supporting Families with Parental Mental Illness Provincial Working Group.
- Werry Workforce Wharaurau *Supporting parents healthy Children For the ICAMH and AOD Workforce.*
- The white paper (for vulnerable children volume 1, May 11, 2011
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- The Christchurch Health and Development Study: An overview and some key findings.
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- Living with addiction: Exploring the issues for families. Helen Moriarty, Maria Stubbe, Sarah Bradford, Sophie Tapper, Blue Skies Report, September 2010
- Waikato DHB Whānau Participation Protocol. Reference No. 0896
- 100 ways to support recovery. A guide for mental health professionals. Rethink recovery series Vol. 1, Mike Slade 2009.
- Weissman, M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D., & Verdeli, H. (2006). Offspring of depressed parents: 20 years later. *The American Journal of Psychiatry*, *163* (6), 1001-1008.
- Creating Partnerships: A New Zealand Guide to Including Families in Mental Health Assessment and Treatment. Richard G.Whiteside and Frances E.Steinberg, 2003
- Queensland Health. (2012). Working with parents with mental illness-risk and protective factors. Queensland Government. Brisbane, Australia**.**
- Māori health models – Te Whare Tapa Whā.http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

- NZNO guidelines for nurses and other healthcare workers on the Section 195A amendment to the Crimes Act 1961-II.
- Privacy Act 1993 www.legislation.govt.nz
- Royal Australian and New Zealand College of Psychiatrists. (2000). *Involving Families: Guidance notes* .Wellington: Ministry of Health.
- The Assessment Framework Triangle Social work Now April 2011 DHB Policy and procedure (Health Care Act Safety of Subsequent Children) www.familiescommission.org.nz
- Treatment or neglect of child or vulnerable adult. Family Psycho education – An Evidenced Based Practice. U.S Department of Health and Human Services, SAMHSA.
- *Social Work Now: April, 2013* *www.practicecentre*

5.2 External Standards

Health and Disability Services Standards NZS 8134: 2008

5.3 Associated Waikato DHB Documents

- Local Partnership and Communication Protocol between Child Youth and Family and Mental Health and Addictions Service
- Mental Health and Addictions Advanced Directive procedure (Ref. 2181)
- Mental Health and Addictions Integrated Care Pathway policy (Ref. 1703)
- Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others procedure (Ref. 5241)
- Mental Health and Addictions Recovery Planning guideline (Ref. 5998)
- Mental Health and Addictions Screening and Triage of Referrals to the Adult Mental Health and Addictions Service procedure (Ref. 3243)
- Mental Health and Addictions Whānau Participation protocol (Ref. 0896)
- Waikato DHB Health Information Privacy policy (Ref. 1976)
- Waikato DHB Interpreters and Translation policy (Ref. 0137)
- Waikato DHB Violence Intervention Programme – Child Protection policy (Ref. 1809)
- Waikato DHB Violence Intervention Programme – Intimate Partner Violence policy (Ref. 2202)

Waikato District Health Board

Protocol

Whānau Participation

Protocol Responsibilities and Authorisation

Department Responsible for Protocol	Mental Health & Addictions Services
Document Facilitator Name	Cara Thomas
Document Facilitator Title	Director Community Mental Health & Addictions Service
Document Owner Name	Cara Thomas
Document Owner Title	Director, Community Mental Health & Addictions Service
Target Audience	Staff, service users and whānau
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Protocol Review History

Version	Updated by	Date Updated	Summary of Changes
06	G O'Brien	01 05 19	Change from policy to protocol document. Inclusion of current practices in involvement of whānau in service delivery development.. Inclusion of whānau support, care and learning development.

Whānau Participation

Whānau Participation

1 Overview

1.1 Purpose

This document outlines principles and practices of whānau participation at Waikato District Health Board (DHB) Mental Health & Addictions (MHAS). These principles and practices will ensure employees involve whānau in service and organisational processes and support the needs of service users, including parents who are service users, their children and young persons.

1.2 Scope

Legislation, professional standards, cultural practices and national policy require MH&AS to have whānau participation processes at an individual and systemic level.

In an environment where health services are expected to use their resources effectively, strengthening the natural supports that people already have is an effective and sustainable approach to support recovery and wellbeing.

Working with the whānau of service users, including children and young persons, is recognised as a core skill for all staff working in the Waikato DHB Mental Health & Addictions Services (MHAS).

Waikato DHB Mental Health & Addictions Services employs a strengths-based approach which protects and strengthens parenting capability and builds the resilience of children and young persons.

Service users coming from a Māori, Pacific, Asian, migrant and refugee perspective will often come from a collectivist paradigm where whānau and culture are essential contributors to the health and wellbeing of a person.

New Zealand government policy and research has highlighted the wellbeing needs of children/ and young people who have a parent or whānau member with mental health and/or addiction problems.

1.3 Patient / client group

All MHAS service users (community and inpatient) including children, young persons and/or vulnerable dependent adult/s who have a service user as parent or caregiver.

1.4 Exceptions / contraindications

There are no exceptions to this protocol.

1.5 Definitions

Whānau	Family/whānau is not limited to relationships based on blood ties. Family/whānau can include a person's extended family/whānau, their partners, friends, advocates, guardians, or other representatives. In the area of mental health and addiction, the person who is unwell decides who his other family/whānau is. Ref: When someone you care about has a mental health or addiction Issue. HDC 2014 The service user's own definition of whānau guides this choice and may include: • Relatives of the proposed service user (including spouse or partner) • Mixture of relatives, friends and others in a support network • Only non-relatives
Child/young person	• People 0 - 13 years • Young person of or over the age of 14 years but under 19 years
Service user	The person who is receiving care and treatment from MHAS
Vulnerable adult	A person unable by reason of incapacitation (e.g. detention), age, sickness, mental impairment or any other cause, to withdraw from and/or relinquish the care or charge of another person
Parent	A broad definition of parent needs to be used which refers to: • Fathers, mothers and any other family or non-family members who play a significant caregiving role for one or more dependent children. • The identified parental figure/s as deemed by the service user, who acknowledges/accepts the significant role of caregiving and the responsibility of care for the identified dependent children.

2 Clinical Management

Roles and Responsibilities. At first, and subsequent contact, negotiate with service user and whānau, ways in which whānau can participate in service user recovery process through assessment, recovery support and planning.

Establish connection and rapport with whānau in such a way that they feel understood, listened to, informed and supported.

If a service user does not give consent, whānau are still entitled to receive access to support and appropriate information.

Provide whānau with access to relevant information they need to support their whānau member's recovery and maintain their own wellbeing including access to cultural supports.

Find out whether service users are parents and facilitate access to parenting support if required along with access to appropriate supports for children and young persons.

Address abuse or neglect concerns for children, young persons and vulnerable adults (which can include service user) with appropriate services.

It is intended that whānau participation processes are in place for service planning, service delivery and evaluation in MHAS. The Whānau Advisor will provide leadership to assist Waikato DHB in these processes.

2.1 Competency required

All staff working in the MHAS are responsible for ensuring their practice is up to date with appropriate learning about the inclusion of whānau and attend regular whānau education forums.

2.2 Equipment

IT electronic devices access as we are a paperless service.

2.3 Protocol

Whānau Advisor/s will have input to serious incident review process and support senior leadership with whānau liaison processes after serious incidents and complaints.

Whānau feedback mechanisms including surveys, focus groups and telephone interviews will be in place. Recommendations from feedback will be added to quality plans and service improvement activities. Summary of feedback is visible to the public.

MHAS staff will have access to training, education and resources on working with and supporting whānau.

Each service will have processes to ensure whānau are included in partnering and have access to helpful information and education to support their whānau member's recovery and maintain their own wellbeing. (especially rural community mental health services)

Waikato DHB MHAS Whānau Caucus will be chaired by the Whānau Advisor who will organise regular educational forums for whānau in the Waikato DHB health area and facilitate whānau input into whānau information and participate in co-design of MHAS projects.

The Whānau Advisor will collaborate and consult with relevant regional and national groups to enhance whānau participation processes locally, regionally and nationally.

Children of parents with a mental illness and/or addiction issues face particular vulnerabilities. Supporting children and young persons is the responsibility of all services so that they are protected and develop resilience.

Supporting whānau resources are available within Waikato DHB MHAS, including but not limited to:

- Training through learning and development
- Resources for parents

- Resources for children
- Resources for young people
- NGO support
- Web-based information, e.g. http://supportingparentsnz.org/

2.4 After care

Evaluation of the whānau participation protocol is completed in partnership with the clinical team, service user, the whānau advisor and whānau representation to ensure the MHAS response to whānau inclusion in service decision making.

3 Patient information

Clinicians ensure the service user and whānau are informed of their rights – under the Code of Health and Disability services consumer's rights.

In the community and inpatient services people are provided with verbal explanations of their rights in accordance with the Privacy Code 1993 and the Health Information Privacy Code 1994 and the Code of Health and Disability Services Consumers' Rights. Limits to confidentiality based on risk of harm to self and others must also be outlined.

All clinical areas will have displayed and have written information easily accessible on the following:

- Code of Health and Disability Services Consumers' Rights
- Nationwide Health and Disability Advocacy Service
- Feedback, compliment and complaint processes
- Supporting Families Waikato Family

4 Audit

4.1 Indicators

- Bi monthly file audits will include reviewing the whānau involvement in service user decision making.
- Bi monthly audits on whānau involvement in MH&A service co-design programmes, projects and planning

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

Whānau of all ages and from different cultural backgrounds can struggle in the early stages of seeking help for a whānau member or friend who may be having mental health or addiction issues. Early access to reliable information, support and services can reduce the distress and long-term effects for all concerned.

Early access is particularly important for children and young people during their developmental years. In addition, we know that children of parents with a mental health **and/or addiction issues** are at greater risk than their peers of developing mental health **and/or addiction issues** themselves. However we also know that "risk does not equal destiny" and there are many ways that the risk can be reduced.

The wellbeing of the whānau is vital for them to be holders of hope. Knowledge and access to resources in the community are crucial steps in empowering whānau to help themselves and aid their own healing.

5.1 References

- Te Rau Matatini Staff. (2014). A Mental Health and Addiction Workforce Framework: A Whānau Ora Approach 2014-2017.
- Health and Disability Service Standards 2008.
- Ministry of Health. 2012. Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand. Wellington: Ministry of Health.
- Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists. {2000). Involving families - Guidance for involving families and whānau of mental health consumers/tangata whaiora in care, assessment and treatment processes. Wellington: Ministry of Health on behalf of the Royal College of Australian and New Zealand Psychiatrists, the Health Funding Authority, and the Ministry of Health; available at http:/ / www.health.govt. nz.
- Ministry of Health. 2008. Let's Get Real: Real Skills for people working in mental health and addiction. Wellington: Ministry of Health.
- Ministry of Health. 2018. Mental Health and Addiction Workforce Action Plan 2017-2021 (2nd edn). Wellington: Ministry of Health.
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- Ministry of Health. 2015. Supporting Parents, Healthy Children. Wellington: Ministry of Health
- Mental Health Commissioner. Health and Disability Commission (HDC) (2014). When someone you care about has a mental health and addiction issue

5.2 Legislation

- Code of Health & Disability Services Consumers Rights 1996
- Crimes Act 1961 (Amendments 2012)
- Health Information Privacy Code 1994
- Mental Health (Compulsory Assessment and Treatment) Act 1992 & Amendment Act, 1999
- Vulnerable Children's Act, 2014

5.3 Associated documents

- Child Abuse Neglect, Care & Protection
- Complaints Management
- Consumer Participation
- Family/ Whānau Consultation & Information Sharing Requirements
- Principal Caregiver
- Partner Abuse Intervention - Family Violence
- Reportable Events
- Tikanga Best Practice
- Visitors policy

6 Disclaimer

No policy can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Waikato DHB protocol to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual service user/patient falls outside of the boundaries of this protocol.

Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions Service
Document Facilitator Name	Peter Dean
Document Facilitator Title	Clinical Director Acute Adult and Forensic Mental Health and Addictions Service
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director, Mental Health and Addictions Service
Target Audience	All Mental Health and Addictions Service health professionals
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
5	Peter Dean	August 2022	Change in format from protocol to procedure. Changes made to promote staff understanding.
4	Carole Kennedy	May 2018	Positive risk approach: Person centred care

Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others

Contents

Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others

1 Overview

1.1 Purpose

This procedure provides a framework for a consistent approach to clinical risk assessment and risk management. The aim is to minimise adverse outcomes for tāngata whaiora and their whānau who access Mental Health and Addictions services at Te Whatu Ora Waikato whilst enhancing ōritetanga (equity), rangatiratanga (self-determination) and wairuatanga (the distinctive identity of the person).

1.2 Staff group

This procedure applies to all Mental Health and Addictions registered health professionals involved in clinical care.

The Consult Liaison service in respect to this procedure is a community psychiatric service provided to Waikato Hospital.

1.3 Patient / client group

All tāngata whaiora within the Mental Health and Addictions services will have a current risk assessment as part of everyday practice.

1.4 Exceptions / contraindications

There are no exceptions to this procedure.

1.5 Definitions and acronyms

Clinical Risk Assessment	Clinical risk assessment is a dynamic and continuous process of evaluating the risk of adverse events. It is a clinical judgement based on the gathering of historical and current information through the processes of reviewing case notes, engagement, communication, investigation and observation. This leads to the identification of specific risk factors related to the tāngata whaiora and the circumstances in which they may occur.
Risk Formulation	Risk formulation is a narrative account of how identified risk and protective risk factors combine to increase and decrease risk
Risk Management	Risk management is the development of strategies of clinical care aimed at minimising the identified risk from occurring or to reduce the degree of potential harm

2 Clinical management

2.1 Roles and responsibilities

Clinicians

All mental health and addictions clinicians are responsible for:

- Conducting a risk assessment: a risk assessment is an essential component of a mental health and addiction assessment.
- Ensuring all documentation is adequate: All risk assessment and risk management activities are documented in line with the risk procedure.

Managers

All Charge Nurse Managers and Team Leaders are responsible for providing access to clinical supervision, and supporting staff to access learning opportunities to enhance their practice.

2.2 Competency required

All registered health professionals in the mental health and addiction services are responsible for ensuring their practice is up to date with appropriate learning and attend clinical supervision regularly.

Are all regulated under the Health Practitioners Competence Assurance Act 2003 or Social Work Registration Act 2003 and are responsible to their respective governing body that regulates their profession.

All clinical staff must have attended and completed the Mental Health and Addictions Service required orientation programme.

2.3 Equipment

Access to clinical workstation.

2.4 Procedure

2.4.1 Risk assessment

Risk assessment is ongoing and part of all clinical interactions and will include the identification of an individual's *static risk factors*- situations that are historical (that is, they have already occurred) or are enduring (factors that lead to risk relative to others in a stated population). This could include information from previous contacts with the mental health and addictions service.

Information from risk incidents, will include a factual description of:

- when they occurred
- what happened
- the context (including if possible, an understanding of the dynamic internal and dynamic situational risk factors at the time)
- the outcome of the risk event

- the tāngata whaiora and the whānau view on what the intent of the risk behaviour was
- Identification of *dynamic internal* factors – tāngata whaiora current mental state (this includes mental illness, and also includes other states, such as anxiety, agitation, anger, helplessness) and the tāngata whaiora current physical state which could impact on the risk
- Identification of the *dynamic situational* factors (factors that are external to the tāngata whaiora). These can for example include factors such as access to means for suicide or harm to others for example weapons, loss of relationships, housing or income, or the actions of other people that affect risk for the tāngata whaiora
- Tāngata whaiora strengths and protective factors for risk reduction, from their perspective and from the perspective of whānau.
- The viewpoints of whānau / caregivers about the current risk and possible risk management strategies
- In the inpatient unit a violence risk assessment is completed daily using the Dynamic Appraisal of Situational Aggression (DASA) tool
- Service specific risk assessment tools may be used such as HCR-20 in Forensics, and specific tools in Perinatal and ICAMHS to guide assessment and formulation

Assessment of whānau and child safety issues will follow the relevant Te Whatu Ora Waikato policies and guidelines https://intranet.sharepoint.waikato.health.govt.nz/Pages/Policies%20and%20Guidelines/Vulnerable-persons-policies-and-guidelines.aspx

2.4.2 Risk formulation

Risk formulation is a structured description of the risk information that has been recorded in the history and dynamic internal / situational sections.

A risk formulation will describe the nature and context in which the risk behaviour/s is most likely to occur, including internal and situational factors that increase the risk. It will also incorporate statements regarding seriousness, imminence, who the likely people affected might be, and the availability of the means and opportunity to carry out the harm.

2.4.3 Risk management

Risk management plans will be discussed with the tāngata whaiora and their whānau, unless clinically contraindicated, before being enacted.

The management plan will identify interventions for the individual that will reduce or contain risk behaviours, including:

- Interventions to address dynamic internal risk factors contributing to risk (for example, use of medication; use of ‘talking; treatments)
- Interventions to address situational factors contributing to risk (for example interventions to address social stressors including relationships; accommodation and

financial situation; access to alcohol and illicit substances; access to weapons; access to potential victims)

- Strategies for building on existing strengths and protective factors to reduce risk
- Resources which are immediately accessible to the tāngata whaiora, whānau and clinical team to support risk reduction and strength building
- "Guarantees of safety" or "no-suicide' contracts are contraindicated and are not to be asked of tāngata whaiora by clinicians.
- In certain situations, risk will appropriately be managed by (continued) admission to hospital including use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- In the inpatient setting a risk management strategy involves the use of levels of observation as identified in the Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (5238)

The management plan must reflect the changes to risk over time, given the dynamic nature of risk.

Risk management strategies will show why strategies were chosen for a tāngata whaiora. In some circumstances it is useful to briefly describe why other strategies were not used (for example, these may have proved unhelpful for the tāngata whaiora at previous time, the tāngata whaiora or whānau considered they would increase risk, or the resource may not have been available).

Risk management strategies will reflect each risk that has been identified.

2.4.4 Risk assessment documentation

Risk assessment documentation:

- Is to be formulated in terms of seriousness and in the context in which risk behaviours are most likely to occur. This will include the nature and magnitude of the potential harm, the imminence and frequency of risk, the frequency of risk behaviours, and the circumstances that may increase risk
- Is entered into a progress notes and recorded on the Risk Assessment + Pattern Analysis form in Clinical Workstation (CWS)
- Will be clear and concise and inclusive of both static and dynamic factors
- That includes information supplied by others (any source) has the source of this information documented
- Discussion with other team members about risk are documented

The Risk Assessment + Pattern Analysis CWS template is to be reviewed and updated when an event has occurred and at 3 monthly reviews.

Pattern analysis involves the identification and formulation of each contributory factor that is likely to result in significant risk behaviours, including both internal and external factors.

2.4.5 Risk plan reviews

Risk plan reviews must occur:

- At a tāngata whaiora first contact with the service
- When a tāngata whaiora is admitted to an inpatient ward
- At a minimum of every shift for inpatients and every 91 days in the community. However caution should be used in sticking rigidly to these pre-set review times, as risk is not static and review of management plans must occur as indicated by circumstances.
- During times that might be associated with increased risk e.g. return from unauthorised leave or transfer of care

Risk plan reviews must be documented, demonstrating an evaluation of the existing plan and include who was involved in the evaluation.

Although the assessment of risk is a function of the multidisciplinary team and includes the input of all team members in both inpatient and community, the keyworker is responsible for maintaining an oversight of the risk assessment and planning process in community and forensics within their care coordination role. In inpatients the SMO is responsible for ensuring that the Risk Tool on CWS is filled out by their multidisciplinary team before tāngata whaiora are discharged from the unit.

Documentation of risk reviews is as follows:
- Day to day review of risks are documented in the progress notes
- Overarching formulation of risk is documented in the risk tool
- Detailed management plan of risk is in the recovery plan

Incidents and 'near misses' are reported in accordance with the Te Whatu Ora Waikato Incident Management policy (0104). Information from the follow up of clinical incidents is a component of risk plan reviews as appropriate.

2.5 Potential complications

Non-engagement and / or leave prior to completion of assessment.

3 Patient information

Clinicians ensure the tāngata whaiora and whānau are informed of their rights. Limit to confidentiality based on risk of harm to self / others must also be outlined.

All clinical areas will display and have written information easily accessible on the following:

- Code of Health and Disability services Consumers' Rights
- Nationwide Health and Disability Advocacy service
- Feedback and complaints processes
- Supporting Families Waikato Family Code of Rights

The provision of person and whānau information is documented in the clinical record.

4 Audit

4.1 Indicators

- Inpatients – current risk is documented every shift as a minimum requirement in the progress notes.
- Community – tāngata whaiora have a current risk review completed in accordance with the requirements of this procedure

4.2 Tools

- Mental health and addictions audit tools aligned with this procedure

5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Keyworker procedure (1558)
- Mental Health and Addictions Leave – Adult Mental Health inpatient wards procedure (2184)
- Mental Health and Addictions Leave – Puawai inpatient wards procedure (6266)
- Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services procedure (5238)
- Incident Management policy (0104)
- Māori Health policy (0108)
- Vulnerable person's policies and guidelines

5.2 External Standards

- NZS 8134: 2021 Ngā Paerewa Health and Disability Services Standards
- Privacy Act 2020
- Health Information Privacy Code 2020
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1999